



**Senator Moulton testimony on SB 380  
Senate Committee on Health  
February 9, 2012**

Good morning and thank you, Chairwoman and members, for the opportunity to testify on SB 380, otherwise known as the "Family Care" bill.

Since 2000, the Family Care program has served many seniors and individuals who are developmentally and physically disabled. Currently, Family Care serves over 40,000 people across Wisconsin.

The 2011-13 state budget established a cap on the program until the Department of Health Services was able to find efficiencies within the program that would help stabilize it and make it sustainable. DHS is now prepared to implement a plan that will do this.

We have worked with DHS to introduce this legislation to remove the Family Care cap and extend program coverage to seniors and individuals with physical and developmental disabilities in areas of the state that previously were not serviced by Family Care.

Our proposed legislation does the following:

- Repeals non-statutory language in the 2011-13 state budget that capped enrollment in Family Care, Family Care Partnership, the Program of All-Inclusive Care for the Elderly (PACE), and the self-directed services option (IRIS).
- Repeals non-statutory language in the 2011-13 state budget that prohibits the expansion of Family Care to counties that currently do not receive the benefit and are operating under the "legacy" community options and community integration programs.
- Repeals the non-statutory budget allocation in the 2011-13 state budget for "urgent enrollment" funding that was appropriated in conjunction with the enrollment cap.
- Makes no change to the requirement that DHS study various aspects of the cost-effectiveness of the state's long-term care programs.

This bill does not include an appropriation and makes no changes to the Chapter 20 budget schedule.

Thank you for your consideration of this legislation. Family Care is important to people across Wisconsin which is why I am pleased this bill is receiving a hearing today.





## Legislative Fiscal Bureau

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February 8, 2012

TO: Members  
Senate Committee on Health

FROM: Bob Lang, Director

SUBJECT: Senate Bill 380/Assembly Bill 477: Repeal Family Care Enrollment Cap

2011 Senate Bill 380 and Assembly Bill 477 are identical bills that would repeal provisions included in 2011 Wisconsin Act 32 that place an enrollment cap on the Family Care, Family Care Partnership, Program for All-Inclusive Care for the Elderly (PACE), and Include Respect I Self-direct (IRIS) programs. Senate Bill 380 was introduced on January 17, 2012, and referred to the Senate Committee on Health. Assembly Bill 477 was introduced on January 18, 2012, and referred to the Assembly Committee on Aging and Long Term Care.

### BACKGROUND

Family Care is a medical assistance (MA) program that provides long-term care services to qualifying individuals under a capitated, risk-based payment system. The program has two primary components -- aging and disability resource centers (ADRCs) and managed care organizations (MCOs). ADRCs are meant to be a gateway for all individuals in the state in need of long-term care services, providing "one-stop shopping" for information, assessments, functional eligibility determinations, prevention, wellness, and other services relating to long-term care. MCOs provide long-term care services to Family Care enrollees, either through contracts with providers or by providing care directly through their employees. These services include many of the services provided under home- and community-based waiver programs (legacy waivers), non-institutional long-term care services provided under the MA standard plan (commonly referred to as "card services"), and nursing home services.

If the Family Care benefit is offered in a county, eligible individuals must also have the option to instead self-direct their long-term care services through the IRIS program. Individuals enrolled in IRIS receive a monthly budget allocation and choose which long-term care services they receive, and which providers will render these services. The budget allocation cannot be more or less than the cost of services that the person would have received if they had chosen to

enroll in Family Care instead of IRIS. DHS operates both programs under waivers of federal MA laws granted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

Under these programs, individuals that meet both functional and financial eligibility standards are entitled to a full package of home- and community-based services designed to meet their needs. Family Care and IRIS benefits become an entitlement for all eligible individuals residing in a Family Care county 36 months after these benefits first become available. Family Care and IRIS benefits replace the legacy waiver services that were previously available in those counties. Consequently, while individuals who are eligible for Family Care and IRIS are not required to participate in these programs, eligible individuals who choose not to enroll in the programs do not have access to MA services that were previously provided under the legacy waiver programs. MA recipients who are not enrolled in Family Care may still receive medically necessary, MA-funded long-term care services through the standard set of Medicaid benefits, subject to certain limitations. Counties that have not yet chosen to join the Family Care program may continue to administer the legacy waiver programs.

The state offers two additional long-term care managed care programs in addition to Family Care. The Program for All-inclusive Care for the Elderly (PACE) and the Family Care Partnership (FCP) program are managed care programs that provide both acute health and long-term care services to elderly and disabled individuals who are eligible for nursing home care. Enrollment in the PACE program is limited to elderly individuals, ages 55 and older, while both elderly and disabled individuals may enroll in FCP. These voluntary programs are targeted to people that are eligible for both MA and Medicare (dual eligibles).

In the Family Care, FCP, and PACE programs, the state's MA program makes capitation payments to MCOs, which are based on average costs incurred by the MCO and reflect the case mix risk based on each individual's level of functional eligibility, labor costs and administrative costs. In addition to the MA capitation rate, FCP and PACE agencies also receive a Medicare capitation rate for acute care services. As described above, IRIS participants receive a monthly budget allocation and control which services to receive and the amount of payment. A portion of the benefit costs in the Family Care program are offset by mandatory county contributions and savings attributable to the Family Care program's lower costs relative to the legacy waiver programs.

As MA eligible programs, the federal government contributes funding for capitation payments and budget allocations in the Family Care-related programs equivalent to Wisconsin's federal medical assistance percentage (FMAP). Historically, Wisconsin's FMAP has been approximately 60%. The remaining 40% is provided through state GPR or the county contributions.

Under current law, DHS is required to notify the Joint Committee on Finance, under a 14-day passive review process, if DHS proposes to contract with entities to administer the Family Care benefit in new geographic areas. If the Co-Chairs of the Joint Committee on Finance inform the Department within 14 days that it has scheduled a meeting to review the contract, DHS may

only enter into the contract if the Committee approves the contract or if the Committee fails to act on the proposed contract within 59 working days after the date of the Department's notification.

## **2011 WISCONSIN ACT 32**

2011 Wisconsin Act 32, the biennial budget act, prohibited the Department of Health Services (DHS) from enrolling, in the service region of each Aging and Disability Resource Center, more persons into the Family Care, Family Care Partnership, PACE, or IRIS programs than the total number of persons participating in all of those programs in that ADRC service region on June 30, 2011. DHS can only enroll persons into the long-term care programs that are offered in that person's county of residence. The enrollment cap does not apply after June 30, 2013. Months during which the enrollment cap is in effect may not be counted toward the statutory requirement that the Department have sufficient capacity to offer the Family Care benefit to all entitled persons after the first 36 months the benefit is available in a county ("entitlement status").

Notwithstanding the provision described above, Act 32 authorized DHS to enroll any individual into the Family Care, Family Care Partnership, PACE, or IRIS programs who is relocated from a nursing home, intermediate care facility for the mentally retarded (ICF-MR), or State Center for People with Developmental Disabilities if the individual has resided in the facility for at least 90 days, the facility is not licensed, an emergency exists, or the facility is closing or downsizing, during the period of the enrollment cap.

Further, Act 32 prohibited DHS from proposing to contract with entities to administer the Family Care benefit in a county in which the Family Care benefit was not available on July 1, 2011, unless DHS determines that administering the Family Care benefit in such a county would be more cost-effective than the county's current mechanism for delivering long-term care services. This prohibition is in effect from July 1, 2011, through June 30, 2013.

Act 32 provided the Department with \$12,639,000 (\$5,000,000 GPR and \$7,639,000 FED) in 2011-12 and \$12,600,800 (\$5,000,000 GPR and \$7,600,800 FED) in 2012-13 to provide long-term care services and support items that are offered in the Family Care program to individuals who are on the waiting list for a Family Care-related program and who are in urgent need of long-term care services, as determined by DHS. These funds may be used to serve individuals until the individual is permanently enrolled in one of the programs. To date, virtually none of these funds have been expended.

Finally, Act 32 required the DHS Secretary to study the cost-effectiveness of the Family Care, FCP, IRIS, and PACE programs. As described in statute, the study must compare the cost-effectiveness of each program to each of the other programs, the cost-effectiveness of each program to standard MA benefits, and the cost-effectiveness of the care that individuals receive before they enroll in a long-term care program to the care that the individuals receive in a long-term care program. DHS must submit its findings of this study to the Joint Committee on Finance.

As of January 1, 2012, nine MCOs provided services in 57 counties and 35 ADRCs provided services in 59 counties. Family Care, PACE, and Family Care Partnership currently serve approximately 43,400 individuals. Thus, at this time, the Family Care program is not available in 15 counties.

## **BILL SUMMARY**

Senate Bill 380 and Assembly Bill 477 ("the bill") would repeal all of the Act 32 provisions described above, except for the requirement that the DHS Secretary study the cost-effectiveness of each of the long-term care programs and present the findings of that study to the Joint Committee on Finance. As required under current law, both prior to and after the Act 32 changes, DHS would have to submit any proposed Family Care expansions to the Joint Committee on Finance under the passive review process described above.

## **FISCAL EFFECT**

The Department estimates that the GPR cost of repealing the enrollment cap would be \$81.9 million. Applying the unused \$10 million GPR provided in Act 32 for emergency cases to the repeal of the cap reduces the amount needed to \$71.9 million GPR. The bill would not increase funding to support the costs of repealing the enrollment cap. Instead, the Department proposes to implement several initiatives to reduce costs of Family Care and other MA-funded services to the state's elderly and disabled MA populations. The Department's estimates of savings from these initiatives approximately equal the estimated cost of repealing the enrollment cap in the 2011-13 biennium.

*Cost of Repealing Enrollment Cap.* In a December 13, 2011, letter to DHS, CMS indicated it was reviewing the state's proposed waiver amendment to implement an enrollment cap in the Family Care-related programs but added that "until specific approval of an amendment is received, the State is required to continue to operate the waiver as described in the currently-approved 1915(c) waiver application." CMS specified that because Wisconsin's currently approved waiver includes entitlement to waiver services, it is "directing the State to identify any individuals not currently enrolled onto the Family Care or Self-Directed Supports waivers since the July 1, 2011, implementation of the newly instituted enrollment caps, and immediately enroll those individuals in the waiver programs." In order to be in compliance with the CMS directive, the letter indicates that DHS is required to enroll "individuals living in any counties who had or would have had an entitlement to the waivers as of July 1, 2011, and includes individuals who were or would have otherwise been selected for enrollment from the other participating counties." The letter closes by outlining three areas that CMS continues to review in the proposed waiver amendment, including compliance with the maintenance of effort (MOE) requirements in PPACA, the level of tribal consultation regarding the enrollment cap, and any other CMS concerns the state must address.

If the state does not comply with the CMS directive, one possible repercussion is a reduction in federal MA matching funding that would be available to support MA benefits costs. In the past, CMS has withheld federal matching funding from states that have not complied with

its directives. It is estimated that approximately \$798 million FED in 2011-12 and \$952 million FED in 2012-13 will be used to support services provided under the Family Care, Family Care Partnership, PACE, and IRIS programs.

The Department indicates that, if the bill is enacted, it would immediately begin enrolling individuals on the bill's effective date and that those months during which the cap was in place will count toward each county's 36-month phase-in period for entitlement. Prior to Act 32, counties were required to incrementally enroll new Family Care participants over the course of 36 months, after which all financially and functionally eligible individuals would be entitled to the Family Care and IRIS benefits and could be enrolled immediately. In addition to establishing the enrollment cap, Act 32 also required that any month for which the enrollment cap was in place could not be counted toward a county's 36-month phase-in period. If the bill is passed and the Department adheres to its expressed intent, any county that would have reached entitlement status during the duration of the enrollment cap would be deemed to have reached entitlement on the effective date of the bill.

After applying the unused emergency funding provided under Act 32, the Department estimates that the cost of lifting the cap on the Family Care-related programs would be \$29,829,500 (\$11,773,700 GPR and \$18,055,800 FED) in 2011-12 and \$149,271,500 (\$60,096,700 GPR and \$89,174,800 FED) in 2012-13. The estimate is based on a number of assumptions, which are described below.

The Department estimates that the net cost of each new enrollee in a Family Care-related program would be approximately \$2,127 (all funds) per member per month. The net per member per month cost is estimated by starting with the average capitation payment per member per month across all of the Family Care-related programs and then deducting from this amount offsetting cost savings that the Family Care-related programs generate relative to other areas of the MA program, such as fee-for-service nursing home expenditures and the legacy waiver programs. The Department assumed that capitation payments for new enrollees would not begin until March of 2012.

DHS estimates the waitlist for Family Care-related services grew from 5,049 in July, 2011, to 6,740 individuals at the end of November, 2011, an increase of 1,691 individuals. A significant number of the individuals on the waitlist will not be financially eligible for Family Care-related services for a number of years. DHS indicates that the CMS directive does not require the Department to enroll individuals more rapidly into Family Care-related programs than is assumed under the current waiver with CMS. Under current law, individuals in counties that have not reached entitlement would be enrolled under the 36 month phase-in described above. DHS plans to continue this schedule. As a result of lifting the cap, the Department estimates that the total number of individuals enrolled in any Family Care-related program will increase by nearly 10,000 individuals, from approximately 43,165 individuals in February, 2012, to approximately 53,139 individuals in June, 2013. In addition to some individuals from the waitlist, these new enrollments will also include individuals from entitlement counties that are not on the current waitlist.

Based on its analysis of the waitlist, DHS assumed that no more than 40% of individuals that have joined the waitlist since July, 2011, are currently eligible for the MA standard plan and could be immediately enrolled into the program. The Department assumed that the remaining 60% of individuals are either not yet financially eligible for Family Care-related services or will need to go through the financial eligibility process prior to receiving services. It should be noted that individuals needing a nursing home level of care can qualify for long-term care services, including Family Care-related services, at a higher income and asset threshold than is allowed for the MA standard plan. It is possible that more than 40% of the individuals that joined the waitlist since July, 2011, will need to be enrolled if they meet these criteria.

Depending on whether or not a county has reached entitlement status, the Department has established different methods for managing the growth in the waitlists when the cap is lifted. Over the course of four months, counties that have not reached entitlement will enroll all individuals that would have been enrolled if not for the enrollment cap, and will then return to enrolling individuals at the same rate as they did prior to the enrollment cap. Counties that have reached entitlement status while the cap has been in place are expected to enroll 40% of the individuals on their waitlist immediately and then return to a trend similar to what existed prior to the cap. The Department assumes that those counties that were at entitlement prior to the enrollment cap will immediately enroll the lesser of either (a) 40% of their current waitlist or (b) the cumulative projected enrollment during the enrollment cap based on historical trends.

Based on each county's Family Care start date and the 36 month phase-in period, 14 counties were entitled prior to the implementation of the enrollment cap. Another 15 counties reached entitlement status while the cap was in place and will be at entitlement if the enrollment cap is repealed. Of the remaining counties, 25 will reach entitlement in the 2011-13 biennium but after the cap is lifted, four counties would reach entitlement in the 2013-15 biennium, and 15 counties have yet to join the program. The total number of counties listed above is one greater than the number of counties in Wisconsin due to Milwaukee County operating two implementation schedules, one for its elderly population and another for its disabled population.

In its estimate, the Department assumed that the Joint Committee on Finance would approve expansion to seven counties as of January, 2013 (Brown, Door, Kewaunee, Marinette, Menominee, Oconto, and Shawano Counties). Due to the mandatory county contributions and offsetting savings in Family Care relative to the legacy waiver programs, expanding Family Care into new counties generates savings for the state in the short-term. However, as the number of Family Care recipients in a county exceeds the original number of legacy waiver recipients, aggregate costs begin to exceed the savings. The Department's estimate assumes that expansions approved by the Joint Committee on Finance would be at worst cost neutral in the current biennium.

*Offsetting Savings.* DHS indicates that it can fund the entire cost of repealing the Family Care enrollment cap through program changes both within and outside of the Family Care-related programs. DHS has attached savings estimates to some of these initiatives, but may realize savings through other program changes. Total benefits funding for Family Care, Family Care Partnership, PACE, and IRIS, after the enrollment cap is lifted and the urgent needs funding

is deducted, is estimated to be approximately \$1,763 million (\$705 million GPR and \$1,058 million FED) in 2012-13. The Department estimates its proposals will generate savings of approximately \$177.4 million (\$71.9 million GPR and \$105.5 million FED) in 2012-13, or approximately 10% of the estimated costs of Family Care-related programs.

First, DHS estimates that it could save approximately \$36.0 million GPR in 2012-13 by reducing the number of individuals admitted to nursing homes and hospitals as a result of non-compliance with their medication regimen. Numerous studies have been prepared which indicate that various medication management interventions can reduce medicine costs. A number of these studies have been referenced by DHS.

To generate its projected savings, DHS proposes to spend approximately \$1.4 million GPR on medication dispensers to place in the homes of approximately 6,700 elderly, disabled, and mentally ill MA recipients. The Department assumes that 23% of nursing home admissions in Wisconsin are due to medication non-compliance and that medication dispensers can reduce non-compliance by 98%. Through the use of medication dispensers, the Department concludes that it can reduce the number of nursing home admissions related to medication non-compliance from 1,679 individuals to 34 individuals annually. In addition, DHS assumes it can reduce monthly hospital admissions by 10% (or 120 admissions in 2012-13) among disabled individuals eligible only for MA.

As noted above, the Department's estimate for the medication dispenser proposal relies on two key assumptions -- that 23% of nursing home admissions in Wisconsin are caused by medication non-adherence and that medication dispensers can reduce the number of nursing home admissions related to medication non-adherence by 98%. DHS cites a 1984 article by Lee R. Strandberg in the American Health Care Association Journal as the source of the 23% estimate. In the article, Strandberg cites the findings of a 1981 assessment by Oregon's Department of Health Services, which found that 90% of Oregon's nursing home residents did not manage or administer their own medications and that 24% of those individuals did not have similarly severe scores in the other 24 areas assessed. This study may have limited relevance to the DHS proposal for several reasons, including the study's age, the possibility that Oregon's population may not be similar to Wisconsin's, and that Wisconsin has had managed care for many years while Oregon did not in 1981. Wisconsin's current nursing home population is much smaller and has greater care needs (acuity) than it had 30 years ago. In addition, the Oregon study's findings suggest a link between medication adherence and nursing home admissions, but the article does not provide evidence of causation. Although medication management might have been the most severe need for the individuals assessed, they may have actually been admitted to a nursing home for any number of other reasons.

In addition, this office was able to find one study that specifically attributed a medication dispenser with increasing medication adherence to nearly 98%. As part of their innovations exchange project, the Agency for Healthcare Research and Quality in DHHS has posted on their website a profile titled "Electronic and Telephone Reminders Increase Medication Adherence in Adults with Uncomplicated Hypertension." The profile summarizes a study conducted by The Center for Connected Health in Boston, Massachusetts in 2009 with funding by Vitality, Incorporated, a maker of medication dispensers. In the study, the researchers compared the level

of medication adherence of a control group to that of a treatment group that was provided with an electronic pill bottle cap that flashed when the participant was supposed to take their hypertension medication. If the participant did not take their medication within one hour the system beeped and called the telephone number chosen by the participant to remind them. Under these conditions, the treatment group reported 86.3% adherence, while the control group reported 61% adherence. When participants were paid an incentive of \$15 for every month they achieved at least 80% adherence, the study reported nearly 96% adherence.

As with the Oregon study, the results of the medication dispenser study described above may not be a reliable predictor of effectiveness for Wisconsin's elderly and disabled MA population. Foremost, the study's findings suggest that the medication dispenser in conjunction with financial incentives increased compliance from the control group's 61% adherence to the treatment group's 96%. This would indicate a 35 percentage point increase in medication adherence as a result of the treatment, whereas the Department is assuming a 98 percentage point increase in adherence through its proposal. It should also be noted that the Center for Connected Health study did not report findings regarding the effectiveness of medication dispensers at reducing the number of nursing home admissions.

The study's participants had an average age of 50 years, were relatively affluent, had wireless Internet access, and had uncomplicated hypertension with no comorbid conditions. As part of their hypertension treatment, participants were required to take a single pill once a day. The profile on the DHHS website also notes that the specific system tested works best when a patient has four or fewer medications. It is not clear what extent these characteristics correspond to Wisconsin's elderly, blind, and disabled MA population.

Second, DHS estimates that it could reduce costs by approximately \$14.1 million GPR by reducing the number of Family Care-related enrollees who receive residential care from 39% currently, to 36% of enrollees. This would entail either diverting or assisting 1,600 individuals who would otherwise receive residential care (in assisted living facilities, for example) to instead receive long-term care services in their homes. For each individual who is diverted or relocated, the Department estimates it would save approximately \$1,869 (all funds) per month, which reflects the difference in benefit costs between residential and non-residential enrollees who are elderly. The Department has indicated a number of ways it could use to realize these savings, including more restrictive criteria for allowing enrollees to enter residential settings through Family Care and the I Respect, I Self-direct (IRIS) program.

While DHS indicates it can begin to implement and generate savings from these changes immediately in the IRIS program, in the Family Care, PACE, and Partnership programs the Department will not be able to generate GPR savings for the state until capitation rates for the MCOs are adjusted to reflect these reduced service costs. DHS intends to reduce calendar year 2013 capitation rates to reflect any reductions in service costs, including reduced use of residential services, and will monitor MCO costs in 2012 to determine if calendar year 2012 rates can be adjusted as well.

Third, DHS believes it can reduce the number of new enrollees that enter Family Care-related programs. The Department estimates it can save approximately \$12.3 million GPR in

2012-13 by creating prevention programs and short-term community interventions that will reduce the number of enrollments related to difficulties with falling and chronic disease self management by 1,200 individuals. The estimate is based in part on the \$2,127 (all funds) per member per month net costs of individuals on the waitlist.

Fourth, the Department estimates that it can save approximately \$6.2 million GPR in 2012-13 by increasing the number of nursing home residents that voluntarily relocate to community-based settings by 1,194 individuals. Approximately 50% of the voluntary relocations would be allocated to the Money Follows the Person demonstration which provides an 80% FMAP for the first year of services an individual receives in the community after relocating from a nursing home. DHS indicates it intends to initiate a concentrated effort to identify fee-for-service nursing home residents with relatively low acuity and inform them of the alternatives available to them in the Family Care-related programs. It should be noted that the GPR share of expenditures for these individuals will increase after their first year in the community, but total GPR costs will remain lower than their current nursing home costs.

Fifth, DHS intends to save approximately \$1.2 million GPR in 2012-13 by adjusting budget allocations for some individuals enrolled in IRIS. When an individual enrolls in IRIS, they receive a monthly budget allocation based on their level of care needs. In July, 2010, DHS adjusted its budget allocation methodology after it determined that the method it had been using was resulting in allocations that were larger than the cost of services the individuals would receive in Family Care. As a result, the program now consists of two groups of enrollees -- those whose allocations were determined under the first methodology and those whose allocations are determined using the post-2010 methodology. DHS intends to reduce by 10% the budget allocation for those individuals who are still receiving allocations based on the initial methodology.

Finally, DHS expects to realize savings totaling \$2.0 million GPR in 2012-13 to reflect multiple changes to Family Care benefits, Family Care administration, improved employment opportunities for disabled youth, and increased counseling for disabled youth and their families as the youth reaches adulthood. The Department expects each of these items to generate savings of approximately \$0.5 million GPR in 2012-13. Some of the proposed changes include providing enrollees with more cost information about the program, increasing the emphasis on an enrollee's natural supports, increased MCO flexibility in care management, and a pilot program with the Division of Vocational Rehabilitation to provide employment services for Family Care-related enrollees with disabilities.

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State of Wisconsin

**Department of Health Services**

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Scott Walker, Governor

Dennis G. Smith, Secretary

**Senate Committee on Health  
Testimony of Deputy Secretary Kitty Rhoades  
Wisconsin Department of Health Services  
Senate Bill 380**

**February 9<sup>th</sup>, 2012**

Chairman Vukmir and members of the Senate Committee on Health, thank you for the opportunity to appear before you to testify in favor of Senate Bill 380 which removes the enrollment cap on Family Care, the state's long-term care program for the elderly and those with disabilities.

Family Care and other long-term care related programs serve over 43,000 individuals in Wisconsin who are both financially and functionally eligible to receive benefits. About 75% of individuals served within these programs are individuals who have a developmental or physical disability, while 25% of individuals are frail elderly enrollees.<sup>1</sup>

Wisconsin has been on the forefront of developing effective public-sector long-term care options. In the late 1990's, Governor Tommy Thompson saw the importance of establishing a statewide managed care program for long-term care services. Placements in skilled nursing facilities and the use of Community Options Programs (COP) grew during this time period. When waiting lists were established in COP due to limited funds, counties, providers, and legislators pursued a cost-effective change.

The Family Care program was established to streamline the patchwork of services offered by counties by providing coordination of long-term care services and supports, eliminate waiting lists, and provide resources for people making long-term care decisions. Wisconsin created a

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<sup>1</sup> An Evaluation of Family Care; Wisconsin Legislative Audit Bureau, April 2011.

one-stop shop through new local agencies called Aging and Disability Resource Centers which were designed to offer counseling and guidance for those seeking both public and private long-term care services. Family Care began a national trend that focused on the effectiveness and efficiency of managed care models and the self-directed option under the Include, Respect, I-Self-Direct (IRIS) program.

Recently, the Legislative Audit Bureau released an audit on the state's Medical Assistance program and reiterated the effectiveness of managed care systems in reducing costs for the state's Medical Assistance program. The Audit Bureau stated that "managed care is widely considered to be a more cost-effective method of delivering health care services, because it can coordinate recipients' services, divert recipients from high-cost services to lower cost services that are medically appropriate, and encourage preventative care to help avoid the development of costly health problems."<sup>2</sup>

The Family Care program has proven to the state of Wisconsin that it is a more cost-effective option than the previous county-by-county legacy waiver programs. The average Family Care enrollee had costs of \$3,188 per month while Community Integration Program (CIP) and Community Option Program (COP) enrollees, the legacy waiver programs that existed in counties prior to Family Care, cost about \$3,761 per month.

Over the past several decades, the payments of long-term care services have shifted from individuals to the taxpayers. Nationally, the largest payer of all long-term care services is Medicaid at 42% of total spending.<sup>3</sup> While the largest payer of services is the American taxpayer, the majority of long-term care services are actually provided on an unpaid basis through a person's natural support system by their family or friends.<sup>4</sup>

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<sup>2</sup> An Evaluation of the Medical Assistance Program; Wisconsin Legislative Audit Bureau, December 2011.

<sup>3</sup> Terence Ng, Charlene Harrington, and Martin Kitchener, "Medicare and Medicaid in Long-Term Care," *Health Affairs*, January 2010, Vol. 29, No.1

<sup>4</sup> H. Stephen Kaye, Charlene Harrington, and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?", *Health Affairs*, January 2010, Vol. 29, No.1

Each year, Wisconsin's Medicaid program spends \$3.0 billion in long term care, supports, and other services. It is vitally important that we ensure that Family Care and its related programs are fiscally sustainable.

It is our Department's responsibility to ensure that the benefits Family Care provides are indeed the types of services that are truly needed in providing the right amount of care, at the right place, and at the right time. Ultimately, that is the essence of an efficient and cost-effective long-term care program.

With that in mind, it is important for us to recognize what services potential enrollees require to live well in their own community. When the Legislative Audit Bureau conducted their most recent audit of Family Care, the LAB recommended that the Department utilize its current data to obtain a greater understanding of what individuals needed to live in the most cost-effective setting.

The Department has surveyed potential enrollees to understand what those individuals need. In particular, the survey shows that:

- 81% of individuals on the wait list live in their own home, apartment, or relatives home
- Most individuals on the wait list want to stay where they currently reside once they enter into the Family Care or IRIS program.
- While many individuals receive support from family and friends now, these individuals identified that additional supports are needed. The top three services requested by those on the wait list includes:
  - o Laundry or chore services
  - o Personal care services (bathing, dressing, eating, toileting, grooming, etc.)
  - o Transportation services

With this information, we can begin to understand how to better serve individuals within Family Care in the most effective setting by providing them what they truly need. The cost-savings initiatives that the Department has put forward enhance the ability for the Department to further utilize sustainable community-based initiatives. These reforms depend on seven key items. We have introduced these items to consumers, providers, Managed Care Organizations, legislators,

stakeholders, and all other Wisconsin citizens to receive feedback and understanding of the program.

These reforms include:

- Strengthening employment supports
- Ensuring family care administrative and program efficiencies
- Realigning family care benefits
- Enhancing IRIS and self-directed supports and providing greater program integrity
- Supporting living well at home and in the community
- Promoting care in more integrated residential settings
- Enhancing programs for youth in transition

We will be holding several town hall meetings throughout the state to gain in person feedback on our reforms. We will announce dates and locations for those town hall meetings as they are finalized. For those who cannot attend a meeting in person, we welcome written comments either through the Department's website or through the mail.

After the passage of Senate Bill 380, the Department would begin to enroll individuals who are currently determined to be eligible for the program. The Department supports this legislation and looks forward to continuing its successful relationship with all stakeholders to provide cost-effective, quality care to the thousands of individuals that we serve.

Coupled with the ability for individuals to choose between Family Care and the Include, IRIS program, the Department of Health Services can nurture an environment where long-term care providers provide the right care, in the right place, at the right time, and for the right price.

I would be happy to answer any questions that you may have at this time.

# Make It Work Milwaukee! Coalition

*Strengthening Milwaukee County through better health and human services*

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SE Wisconsin Chapter  
American Red Cross in  
Southeastern Wisconsin  
Autism Society of Southeastern  
Wisconsin  
Automated Health Systems  
Bell Therapy, Inc.  
Curative Care Network  
Coalition of Wisconsin Aging  
Groups  
Community Advocates  
Disability Rights Wisconsin  
Easter Seals Southeast Wisconsin  
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HealthWatch  
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Independent Care Health Plan  
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Council of the Milwaukee Jewish  
Federation  
Jewish Family Services  
Justice 2000, Inc.  
Life Navigators (Formerly ARC)  
Managed Health Services  
Mental Health America of Wisconsin  
Meta House, Inc.  
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Vital Voices for Mental Health  
Wisconsin Community Services, Inc.  
Wisconsin Council on Children  
and Families  
Gwen Jackson

February 9, 2012

To: Senator Vukmir and members of the Senate Health Committee

From: Make It Work Milwaukee! Coalition

Re: *Support for SB 380 - Removing the Cap on Enrollment in Family  
Care, IRIS, and other long term care programs*

I am here today on behalf of Make It Work Milwaukee, a cross disability and aging coalition of over 40 organizations that is committed to supporting a meaningful life in the community for older adults and people with disabilities. Our agencies are on the frontline serving people in need. As Director of the Milwaukee office of Disability Rights Wisconsin, I work with my colleagues to serve people with disabilities throughout southeastern Wisconsin, including many who are anxiously waiting for the caps to be lifted, so they can maintain their independence in the community.

We want to thank Senator Vukmir for convening today's hearing and for her strong support for lifting the caps and for advancing Senate Bill 380. Thank you also to the bill's author, Senator Moulton for his leadership on this important issue, Senators Erpenbach and Carpenter for their co-sponsorship, and Senator Galloway for her support for lifting the caps. We in Milwaukee deeply appreciate your support of this legislation which is so important for our community.

The Make It Work Milwaukee! Coalition urges members of the Legislature to lift the cap – it's the right thing for people and the right thing for the budget. Community based long term care services like Family Care and IRIS have a long history of bipartisan support in Wisconsin because they *are more cost effective than institutions and better for people.*

In a tight budget, community based care makes more effective use of our limited dollars. The average cost of Family Care is \$2,800 per month vs. the average nursing home cost of over \$5,000. Costs in other institutional settings such as the Milwaukee Mental Health Complex range from \$16,500 to \$40,920 a month. Family Care and IRIS allow people to continue living in their own homes at less cost than these alternatives.

Since the caps have been put in place, waiting lists have grown across the state and families are stretched beyond their limits. Residents of Milwaukee County continue to feel the pain, as the county with the longest waiting lists in the state. Approximately 1500 people with disabilities, aged 18- 59, continue to languish on waiting lists. A new waiting list has been established for older adults and has had as many as 700 people – after a decade of no waiting lists for seniors. Young adults with disabilities are graduating from high school with no hope or help.

I'm here today to speak to you on behalf of thousands of Wisconsinites who cannot be here: those on our waiting list who are in urgent need of service and are unable to travel to Madison because of their disability or frailties of aging. I wanted to share with you the story of a Milwaukee family who could not wait any longer.

This is a story about a young man who was gravely injured in a terrible diving accident. His parents, both in their 80s, have devoted themselves to his care for many years, following the accident. Knowing his parents' ability to care for him would come to an end and desperate to stay at home, this young man got on the waiting list over six years ago. It was this families' heartfelt prayer that with the support of Family Care, their son could continue to live at home, even as their ability to care for him diminished. Tragically, several months after the caps went into place, both parents experienced serious health problems – Mom ended up on dialysis and Dad was hospitalized with heart problems. With the family in crisis and unable to care for their son, this young man and his devoted parents had no choice but a nursing home placement – at a terrible human cost and very significant financial cost.

The caps have also taken a terrible toll on frail elderly and their families – in our county, waiting lists have grown rapidly after ten plus years of no waiting lists for seniors. Statewide, more than one-quarter of the people waiting are over age 85 and 121 are over 96 years old. How much longer can these elders wait for the promise of Family Care?

We all know – there is a better way. Your vote to lift the cap on Family Care and IRIS will mean families like this one will get the supports they need. Disability and aging ultimately touch every family: our lives can change in moment and long term care supports can become an essential lifeline. Programs like Family Care and IRIS truly provide a lifeline for thousands of families – and also provide a good investment for the taxpayer, saving tens of thousands of dollars per person by keeping people out of costly institutional care. IRIS has been tremendously successful because it supports self determination, giving members greater choice and control over the services and supports they need.

We must not forget there is a significant risk to Wisconsin if this legislation does not advance. If the legislation to lift the caps does not become law, there is substantial danger that CMS will withhold Medicaid funds. As noted in the January 27 Legislative Fiscal Bureau memo to Senator Darling and Representative Vos, Wisconsin faces a potential loss of \$1.7 billion in federal funds if the state does not comply with the CMS directive. We urge you to act now to advance SB 380 and lift the caps, ensure that Wisconsin is in compliance with CMS and retains Federal Medicaid funding.

A vote for this bill will also allow the possibility of expanding Family Care to additional counties where waiting lists continue to grow with no hope life sustaining services. Today you will hear about studies that demonstrate that Family Care is more cost effective than the legacy waiver programs that it will replace in expansion counties. However, it is important to note that simply passing this bill does not mean expansion will advance. Counties must approve expansion. DHS must first certify that the expansion is cost effective; the Legislative Fiscal Bureau would then provide analysis because the expansion would have to go through the Joint Finance Committee passive review process before expansion would be approved.

With your support and leadership, Wisconsin can lift the cap on community services and ensure that people with disabilities and older adults can stay in their homes, maintain their independence and health, and receive more cost effective services. Please take action today to keep the community promise and lift the cap on Family Care and IRIS.

#### **Make It Work Milwaukee Coalition Co-chairs**

Barbara Beckert, Disability Rights Wisconsin, Milwaukee Office Director  
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Testimony of Heather A. Bruemmer  
Executive Director of the Wisconsin Board on Aging and Long Term Care  
In Support of SB 380  
Before the Senate Committee on Health  
9 Feb 2012

Chairperson Vukmir, members of the Committee, I am Heather A. Bruemmer, Executive Director of the Wisconsin Board on Aging and Long Term Care. On behalf of our entire agency, I thank you for holding this hearing. Today, I would like to address an extremely important issue from the perspective of our agency's clients, the elderly and disabled consumers of long term care in this state. Our mandate, as expressed in both Wisconsin and federal law, includes the requirement to advocate for the interests of our Family Care clients in their homes, in long term care facilities, and to provide systemic advocacy at the state level.

The Board on Aging and Long Term Care strongly supports SB 380. We encourage the Senate to act swiftly to assure that the long term care service needs of all persons who are eligible to participate in the Family Care program will be met. Fifteen years ago, this state began a process to implement comprehensive and cost effective long term care reform. This effort has developed into a program which people have come to depend and rely upon. Now we must work to fulfill the promise that was made to the most vulnerable among us. The Department of Health Services has assured us that they will be able to install program efficiencies that will allow Family Care services to continue. Failure to enact SB 380 will seriously jeopardize the health and well-being of thousands of vulnerable people who are awaiting enrollment. As well, the state's positive reputation for and caring about its elderly and disabled citizens will be threatened.

The Board on Aging and Long Term Care recognizes that the plan to expand Family Care has not yet been fully implemented. We are not suggesting that Family Care needs to be immediately put into effect in all 72 counties. Expansion plans can be a topic for discussion in the coming months. The issue that most concerns this agency is that people in counties where the program is already in place should not have to wait to receive the services that they are eligible for and that they have been promised. Speaking on behalf of Wisconsin's vulnerable elderly and disabled citizens, we at the Board on Aging and Long Term Care urge you to lift the Family Care caps.

Thank you for your attention and I will be pleased to answer any questions that you may have.



Camden Baun

Please support lifting the caps on family care.

Being put on a waiting list for family support would mean my day to day needs would go unmet.

Having family support available to me right away when I turn 21 would mean my mom won't have to worry about losing her job in order to care for me or be forced to have to put me in an institution.

If caps are not lifted on family care, there will not be a smooth handoff from the CLTS waiver programs that has supported me as a youth to the family support program that I will need to help me with independent living and job skills as an adult.

Please think about priorities when it comes to spending. Alternate care settings cost a lot of money and do not always give people the quality life they deserve.

Please help make this life better for me and better for others by keeping us out of institutions and leaving us in the homes and communities that we have grown a part of.

Instead of stepping backwards, I want to continue stepping forward towards the stars where the possibilities are endless.

Please support lifting the caps on family care.

THE TIME IS NOW!!!





Wisconsin Board for People  
With Developmental Disabilities

Date: February 9, 2012

To: Sen. Leah Vukmir, Chair  
Members  
Senate Committee on Health

From: Chris Thomas-Cramer, BPDD Policy Analyst

Re: Support for SB 380: Relating to Removing the Cap on Enrollment in Family Care and Other Long-Term Care Programs and Allowing Expansion.

BPDD agrees with Governor Walker, DHS Secretary Smith and the sponsors of SB 380 that the Family Care and IRIS programs both offer important supports for people with disabilities and is cost-effective, saving millions compared with the old legacy waivers. For individuals with developmental disabilities, Family Care and IRIS provide the means to live and participate in the community with supports like help getting out of bed and dressed each morning, assistance on the job, and transportation to get around town.

Family Care and IRIS were designed as streamlined one-stop-shop programs that provide quality services and responsibly use public funds with proven cost-effectiveness and efficiency. Quality is affirmed by the 94% of participants who report they are happy with the programs. Efficient use of public funds is demonstrated when cost comparisons are made between Family Care and the inefficient patchwork of programs still found in 15 legacy waiver counties.

According to the Department of Health Services the average monthly cost for a Family Care participant, including nursing home costs is just under \$3,200 per month, compared with nearly \$3,800 per month for participants in legacy waiver counties. This results in savings of more than \$68 million each year per 10,000 Family Care participants compared with those in legacy waivers.

**In addition, since its initial roll-out, Family Care has made great progress in achieving administrative savings with almost 95 percent of funding used to support member services.**

Recent DHS data shows that for the first nine months of 2011, the costs associated with MCO administration of Family Care decreased by 21.5 percent relative to the same period in 2010, accelerating the trend observed in prior quarters. Managed Care Organizations are keeping their administrative costs well below six percent of the dollars they receive—lower than those in legacy waiver programs.

The fiscally responsible option is to roll out Family Care into the remaining counties with legacy waivers. Even with passage of this bill, expansion is not guaranteed. Safeguards are in place that do not allow expansion into new counties unless it is cost-effective. The Joint Finance Committee must approve each expansion after analysis by the Legislative Fiscal Bureau.



Senate Committee on Health

February 9, 2012

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We believe passage of this bill is an urgent issue and that **legislation is needed to lift these caps**. If legislation is not passed, there is significant risk that the Centers for Medicaid and Medicare Services will withhold Medicaid funds. The federal government pays 60% of Family Care costs. As noted in the 1/27/12 Legislative Fiscal Bureau memo to Senator Darling and Representative Vos:

*"If the state does not comply with the CMS directive, one possible repercussion is a reduction in federal MA matching funding that would be available to support MA benefits costs. In the past, CMS has withheld federal matching funding from states that have not complied with its directives. It is estimated that approximately \$798 million FED in 2011-12 and \$952 million FED in 2012-13 will be used to support services provided under the Family Care, Family Care Partnership, PACE, and IRIS programs."*  
(p. 5)

To add perspective to the importance of these programs, it must be remembered that the movement to support individuals with disabilities living in the community has been an unstoppable force for the past 40 years. There is no turning back the clock. If long-term care services are not available, family members quit their jobs to care for their loved ones until forced by age or circumstances to place them in more costly institutions. Without services, students graduate from school to the couch, wasting years of education and potential to succeed in employment and as community members.

Wisconsin has a rich history of providing quality supports to its residents who need daily help to live productive lives. Governor Tommy Thompson knew about the importance of quality long-term care services and had concerns about the inefficiencies and lack of equity in the various legacy waivers, where case managers spent time and resources trying to figure out which mixtures of waivers would draw down federal match. Also, care providers had to take time out from providing care to manage paperwork for confusing systems.

Please be a part of history and lift the caps on Family Care, IRIS, and other long-term care programs and support SB 380. Thank you for your consideration of this testimony. If you have any questions, please contact Beth Swedeen, Executive Director, at 266-1166 or [Beth.Swedeen@Wisconsin.gov](mailto:Beth.Swedeen@Wisconsin.gov).





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## Family Care Testimony February 9, 2012

Good morning. Thank you for this opportunity to testify.

My name is Kate Wichman. I am a retired nurse, an AARP volunteer advocate and a member of Wisconsin's Long Term Care Council. I am here to ask you to lift the caps on Family care as soon as possible. I am not currently on Family Care and hope that my husband and I will continue to be able to care for ourselves at home without the need for these services, but, people that we know and care about are not as fortunate. In addition, we know that we are only a medical crisis away from needing this program.

In 2008, as the financial crisis was draining our retirement accounts, my husband had a stroke. With rehabilitation, Tom has made a pretty good recovery, but at first, he needed significant help at home. Fortunately for us, I was able to care for him at home. Our children are terrific and helped a lot, but they have jobs and families to support. None of them would have been able to stop working for as long as his recovery took. We know what it means to need help. Family Care provides the help that elderly and disabled folks need to stay at home, when they can no longer do it all themselves.



At the last Long Term Care Council meeting we were given a handout which I have attached to my testimony. It is a study done by the Department of Health Services about the people on the waiting list for long term care services. It shows that 4,205 people are on the list. 2/3 of them are over 65. A quarter of them are over 85. And 121 are 96 or older. These aren't numbers, they're real people. At these ages, how long can they be expected to wait?

The Legislative Audit Bureau audit figures show that Family Care is cost effective. The alternatives, hospital and nursing home care are much more expensive. The only other alternative is living independently and declining in place with no help. This is completely unacceptable. Lifting the caps now is critical.

All of us hope for long healthy lives. We think we have planned well for our old age. But a medical crisis can rob any of us of our independence and at the same time, strip us of our financial security. We need this program. We can't leave these people: the old, the infirm, and the poor, without assistance.

Thank you.



# Profile of People Waiting for Long-Term Care Programs

*In November, 2011, an analysis of individuals waiting for publicly funded long-term care programs was conducted. Data derives from the long-term care functional screen; the automated tool used to determine whether an individual is functionally eligible for the Family Care, IRIS, PACE, and Partnership programs. 4205 individuals were included in the sample.*

Ages of waitlist people	# People	% of People
17-25	446	10.6%
6-45	278	6.6%
46-65	864	20.5%
66-75	525	12.5%
76-85	980	23.3%
86-95	991	23.6%
96+	121	2.9%
Total	4,205	100.0%

- 
- Two-thirds of the people waiting are over age 65.
  - More than one quarter of the people waiting are over age 85.
  - 121 people are 96 years of age or older.

Hierarchical Target Group*	# People	% of People
Developmentally Disabled	728	17.3%
Elderly	2,226	52.9%
No Target Group / NA**	21	0.5%
Physically Disabled	1,230	29.3%
Total	4,205	100.0%

\*People with developmental disabilities who also meet another target group are included in the DD category.

- 
- One out of two are frail elders
  - One out of three have a physical disability
  - One out of five have a developmental disability

Length of time on waitlist	# People	% of People
Less than 6 months	2,053	48.8%
6-12 months	1,037	24.7%
Between 1 year & 2 years	847	20.1%
More than 2 years	268	6.4%
Total	4,205	100.0%

- 
- Consistent with the customer survey, half (48.8%) have been waiting 6 months or less.
  - 75% have been waiting for one year or less.

## Activities of Daily Living (ADL)

*Activities of daily living include day-to-day tasks such as bathing, dressing, eating, mobility, toileting, and transferring.*

- Forty percent (40%) of people waiting require assistance with three or more activities of daily living. People who are elderly or who have a physical disability are most likely to require assistance with three or more activities.

- About one quarter (24%) do not require any assistance.

	% with no ADL Needs	% with 3-6 ADL Needs
People with Developmental Disabilities	37.4%	26.6%
Frail Elderly People	21.6%	40.3%
People with Physical Disabilities	21.7%	46.3%
Aggregate	24.3%	39.6%

The following chart shows the percentage of people that require assistance with the specified ADL. The most common activities that people require assistance with are bathing (67%), dressing (49%), and mobility (31%).

	Developmental Disability	Frail Elders	Physical Disability	Aggregate
Bathing	56%	69%	68%	66.5%
Dressing	40%	49%	53%	49%
Eating	21%	20%	20%	20%
Mobility	9%	34%	39%	31%
Toileting	23%	30%	30%	29%
Transferring	7%	28%	38%	27%

## Instrumental Activities of Daily Living (IADLs)

*Instrumental activities of daily living include tasks such as meal preparation, medication management, money management, laundry/chore services, transportation, and access to or use of the telephone.*

- Eighty-eight percent (88%) of people waiting require assistance with three or more instrumental activities of daily living. People who are elderly or who have a developmental disability are most likely to require assistance with three or more activities.
- **Almost every person** waiting for long-term care programs require assistance with at least one instrumental activity of daily living.

	% with no IADL Needs	% with 3-6 IADL Needs
People with Developmental Disabilities	0.0%	91.5%
Frail Elderly People	0.4%	90%
People with Physical Disabilities	0.6%	80.6%
Aggregate	0.4%	87.5%

The following chart shows the percentage of people that require assistance with the specified IADL. The most common IADLs that people require assistance with are laundry and chores (93%), meal preparation (89%), and transportation (80%).

	Developmental Disability	Frail Elders	Physical Disability	Aggregate
Meal Preparation	84%	92%	86%	89%
Medication Management*	82%	77%	63%	73%
Money Management	96%	74%	53%	72%
Laundry/Chore	83%	95%	94%	93%
Transportation**	89%	83%	70%	80%

\* Indicates percentage of people who require assistance among those that take medications

\*\*Indicates the percentage of people that do not drive a vehicle at all.

## Limitations of People Waiting

*The most typical person on the waitlist is an elderly person between 76 and 95 years of age who has been on a waitlist less than six months.*

### Developmental Disabilities: Top Three ADLs and IADLs

1. Bathing (56%)
2. Dressing (40%)
3. Toileting (23%)
4. Money Management (96%)
5. Transportation (89%)
6. Meal Preparation (84%)

### Elderly: Top Three ADLs and IADLs

1. Bathing (69%)
2. Dressing (49%)
3. Mobility (34%)
4. Laundry/Chore (95%)
5. Meal Preparation (92%)
6. Transportation (83%)

### Physical Disabilities: Top ADLs and IADLs

1. Bathing (68%)
2. Dressing (53%)
3. Mobility (39%)
4. Laundry/Chore (94%)
5. Meal Preparation (86%)
6. Transportation (70%)






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## MEMORANDUM

TO: Honorable Members of the Senate Committee on Health

FROM: Sarah Diedrick-Kasdorf, Senior Legislative Associate 

DATE: February 9, 2012

SUBJECT: Support for Senate Bill 380 – Removal of Cap on Family Care Enrollment

The Wisconsin Counties Association (WCA) strongly supports Senate Bill 380 that removes the cap on enrollment in the Family Care and other related long-term care programs.

When the Family Care program was first created, our counties embraced the program to end the waiting lists for long-term care services for the elderly and physically and developmentally disabled populations. In exchange, our counties agreed to contribute tax levy to the program over a five-year period. After five years, each Family Care county contributes an amount equal to 22 percent of its community aids allocation. Implementation of the cap on Family Care enrollment, in essence, broke the promise made to counties when the program was first established.

The bill also eliminates the prohibition on the expansion of Family Care to legacy waiver counties. Prior to passage of the budget, a number of counties were in the planning phase and targeted to implement Family Care in the 2011-2013 biennium. The prohibition on expansion created a have and have not situation in the state of Wisconsin with regard to the receipt of long-term care services. Failure to expand the program to counties that want to implement Family Care costs the taxpayers money. According to a cost-effectiveness evaluation performed by the Department of Health Services (DHS), the average Family Care enrollee has monthly costs lower than individuals enrolled in the IRIS or the legacy waiver programs.

DHS has estimated that GPR funding of \$80 million is needed in the 2011-2013 biennium to lift the cap. The Department has identified program savings through its Long Term Care Sustainability initiative to ensure the state remains within its Medicaid



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WCA Memorandum  
February 9, 2012

budget as more individuals enroll in the program over the course of the biennium. Counties have indicated their willingness to work with the Department on its sustainability initiatives.

Most importantly, counties support Senate Bill 380 because removing the cap is simply the right thing to do. Individuals in need of long-term care services in the state of Wisconsin should not have to wait for vital services such as feeding assistance, medication management, and employment services. It is time to end the cap on Family Care enrollments and allow counties that wish to move forward with Family Care implementation to do so.

WCA respectfully requests your support for Senate Bill 380.



## ELDER LAW SECTION

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February 9, 2012

TO: Senate Committee on Health

FR: Attorney Jane Lokken  
Chair, Elder Law Section

RE: SB 380 – support

The Elder Law Section of the State Bar of Wisconsin is comprised of a cross-section of practitioners who work to protect the rights of our clients and consumers. As attorneys, we work to develop and improve the laws that affect the elderly, and promote high standards of ethical performance and technical expertise for those who practice in the area.

The Elder Law Section, on behalf of Wisconsin's elderly and disabled individuals and their families, strongly supports eliminating the cap on enrollment in Family Care and other long term care programs and the extension of the program to seniors and individuals with physical and developmental disabilities in areas of the state where these programs were not previously available.

Family Care and other long term care programs were implemented to keeping elderly and disabled citizens of Wisconsin in their own homes or home-like settings. No Wisconsin resident person should be institutionalized when community a community placement is suitable. Currently there are nearly 7,000 individuals on waitlists Family Care services. One result of the waitlist is that some families must undergo the trauma of relocation caused by the need to leave one's home for an institution when one has depleted one's own funds.

According to the Wisconsin Legislative Fiscal Bureau, the Department of Health services have identified several initiatives that will cover the cost of lifting the caps and make the programs fiscally sustainable. Another reason this legislation should be passed is that failure to do so could jeopardize Wisconsin's ability to receive federal matching Medicaid funds as the caps have not been approved by the federal government. Thus, the budgetary reason for the caps no longer exists and now there is no reason why the caps and limitations should not now be eliminated.

The Elder Law Section strongly supports SB 380 and the removal of the cap on enrollment of Family Care and other long-term care programs.

Thank you for your attention to this matter. We ask for your support.

*The State Bar of Wisconsin establishes and maintains sections for carrying on the work of the association, each within its proper field of study defined in its bylaws. Each section consists of members who voluntarily enroll in the section because of a special interest in the particular field of law to which the section is dedicated. Section positions are taken on behalf of the section only.*

*The views expressed on this issue have not been approved by the Board of Governors of the State Bar of Wisconsin and are not the views of the State Bar as a whole. These views are those of the Section alone.*

*If you have questions about this memorandum, please contact Sandy Lonergan, Government Relations Coordinator, at [slonergan@wisbar.org](mailto:slonergan@wisbar.org) or (608) 250-6045.*



STATE BAR OF WISCONSIN



Testimony  
Senate Committee On Health  
February 9, 2012  
Re: Senate Bill 380

Good Afternoon -

Thank you for the opportunity to testify regarding Senate Bill 380 today, on behalf of the participants and Board of Directors of Community Care of Central Wisconsin - and on behalf of those (270) individuals in the counties of Langlade, Lincoln, Marathon, Portage and Wood who are currently residing on wait lists for Family Care and other Long Term Care programs.

My name is Jim Canales - I am the Chief Executive Officer for Community Care of Central Wisconsin. With me today is Mark Hilliker - CCCW Chief Operating Officer.

Community Care of Central Wisconsin (CCCW) is the Managed Care Organization under contract with the Department of Health Services to provide the Family Care benefit to residents of north central Wisconsin.

I would like to specifically address three (3) issues in my testimony:

- CCCW program effectiveness and fiscal sustainability
- Participant, or member satisfaction with Family Care in the CCCW service region, and
- People waiting for publicly funded long term care services in north central Wisconsin.

Community Care of Central Wisconsin began operating in July, 2008, succeeding one of the five (5) original Family Care pilot programs, Community Care of Portage County. 900 Family Care participants immediately enrolled in CCCW in July of 2008, and within six (6) months, an additional 1,250 Marathon and Wood county residents enrolled. Langlade and Lincoln counties were the last of the 57 current Wisconsin counties to join Family Care in 2011. 3,200 individuals currently receive Family Care services through CCCW on a daily basis.

I have included a two-sided document with my testimony for your reference, which addresses the first two of the issues I intend to talk about -

- CCCW program sustainability and cost effectiveness, and
- Member satisfaction with Family Care.

Exhibit A reflects direct member care costs that CCCW incurred from 1/1/2009 - 10/31/2011 on a Per Member Per Day basis. Early 2009 PMPD costs reflect care costs that CCCW assumed when legacy waiver clients moved into the Family Care program in large numbers from Marathon and Wood Counties. As you can see, average annual PMPD costs have decreased significantly from 2009-2011. The average PMPD cost for 2009 was \$89.94. That figure decreased to \$87.13 PMPD in 2010 and to \$84.78 PMPD in 2011. Applying the PMPD costs to our current membership of 3,200 members, the PMPD reduction results in an annualized savings of over \$6 million.

CCCW has employed various strategies over the past three (3) years to achieve greater fiscal stability. These strategies have included:

1. Achieving internal cost efficiencies, such as the volume purchasing of high quality Durable Medical Equipment and Disposable Medical Supplies required by our members.
2. Achieving external efficiencies, primarily through collaborative approaches to provider rate setting and service model changes. Additionally, a continuing influx of new service providers into our region has resulted in increased competition and lower vendor pricing.
3. A major change in how CCCW care management staff approach member assessments and care planning. Our interdisciplinary care management teams now use a strength-based approach that focuses on capitalizing on member strengths, rather than deficits, and encourages a greater use of natural supports – family, friends, and community - available to each member.
4. And finally, CCCW has emphasized member usage of the option of Self Direction in Family Care to affect both greater member satisfaction with the process and additional cost savings.

The results of employing these organizational strategies are that CCCW has:

- Now nearly reached our goal of fully meeting our contractual capital requirements, which for 2012 means maintaining a risk reserve of nearly seven (7) million dollars.
- Achieved greater fiscal stability and program sustainability, while at the same time being involved in over 130 institutional relocations in 2011. These relocations saw people move from nursing homes and other institutional settings to community based alternatives, at significant savings to the state Medicaid budget.
- Achieved organizational goals of having at least 20% of our membership self direct at least one of their cares, resulting, as I indicated earlier, in lowered costs and greater member satisfaction.
- Continued to successfully operate a regional model of providing long term care services, in place of the longstanding county home and community based waiver system, at a significantly lower cost.
- And was able to become increasing more cost effective over the past three (3) years, while not at the expense of member satisfaction and quality. Note Exhibit B, which tracks that same trajectory of PMPD costs over this time period as seen in the first exhibit, and includes consistently high member satisfaction levels as noted in DHS reports based on member satisfaction surveys. Additionally, CCCW responded to zero member grievances in 2011, and only six (6) member appeals.

The final point of my testimony relates to the people waiting for enrollment opportunities into Family Care or the IRIS program in our service region. At last count, over 270 individuals were waiting for Family Care or IRIS.

Thank you.

# Per Member Per Day Costs

## Community Care of Central Wisconsin

### 2009-2011

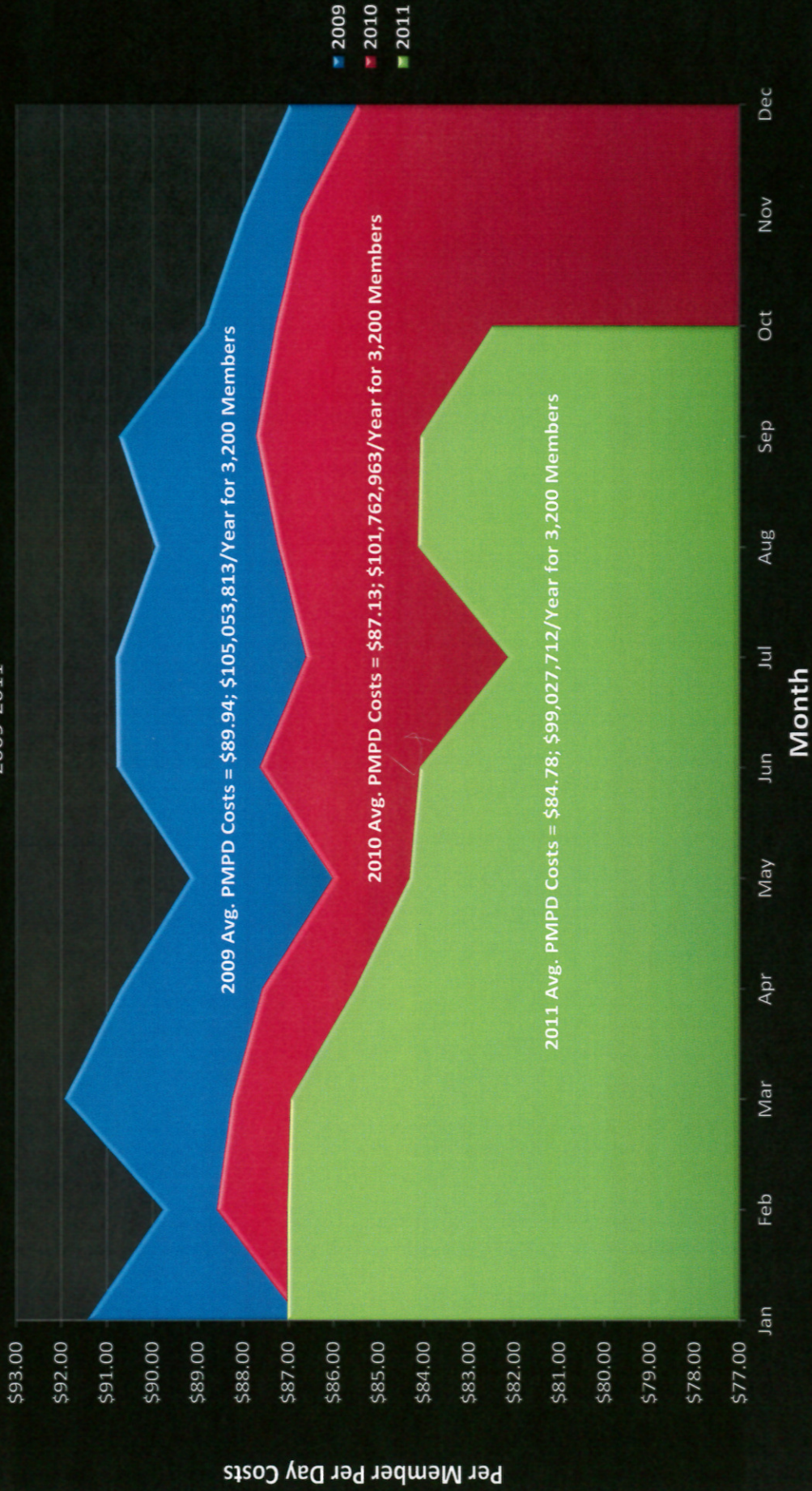


EXHIBIT A



# Per Member Per Day Costs & Member Satisfaction

Community Care of Central Wisconsin

2009-2011

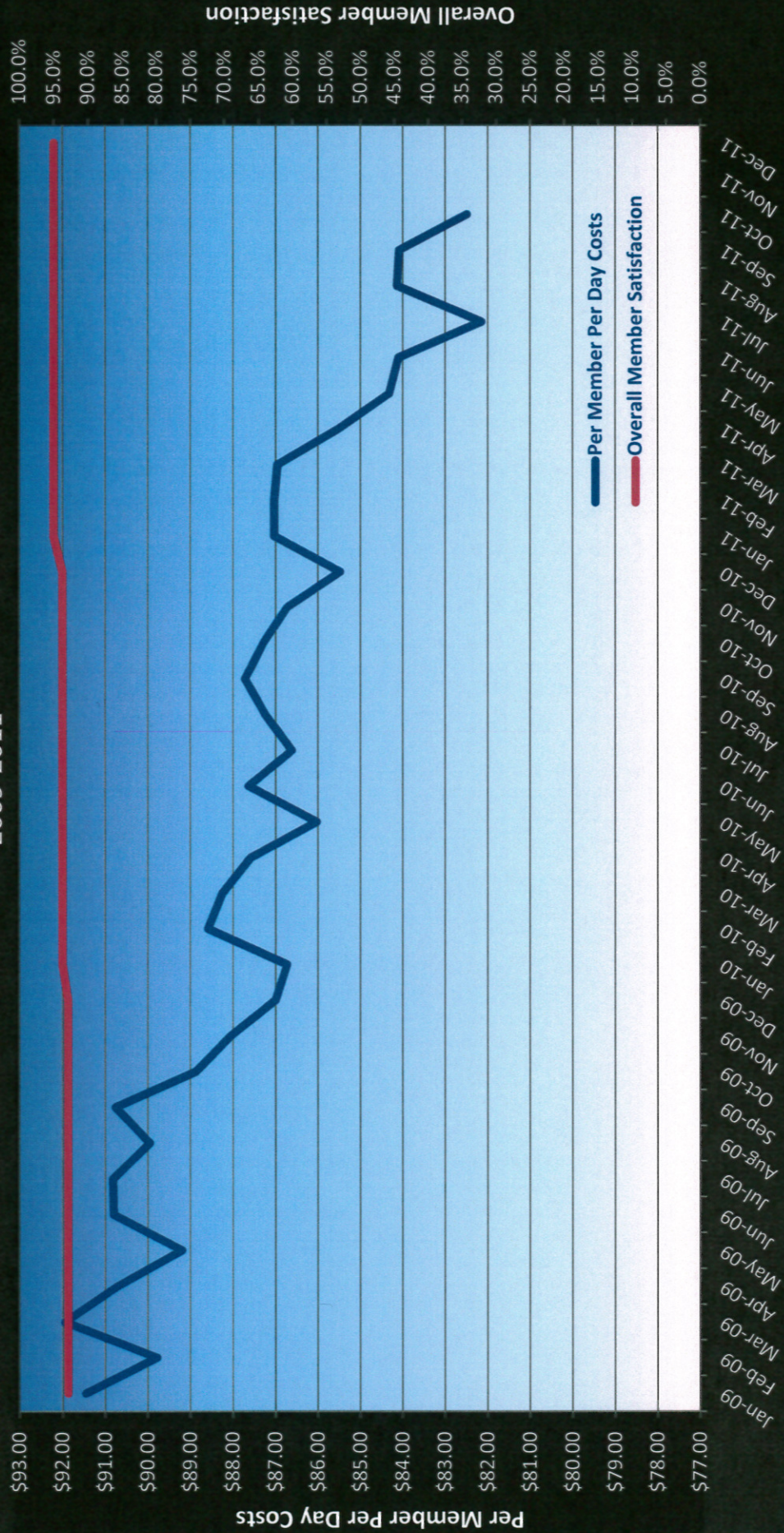


EXHIBIT B



Thank you Madam Chairperson for holding this very important hearing on lifting the caps so everyone can have long term care.

My name is Rick Petzke and I am a Secretary of People First of Stoughton. People first are an advocacy group that represents people with disabilities. I am representing my chapter because I know there are people with disabilities in our chapter that don't receive long term care.

We have people that need help with bathing, housework, cooking, transportation and help on the job. Without the expansion of long term care all these services along with being able to interact in the communities that they live in would be very difficult and almost impossible because of the disability.

Over the long term expanding this would be cost effective. Right now in the State of Wisconsin in Dane County there are roughly 400 people on a waiting list. Research shows that people with disabilities that don't have long term care end up in a nursing home at a cost of \$5,000 a month. If you lift the cap on long term care people with disabilities could stay in their communities at a cost of \$2,800 a month.

When you look at the research from Department of Health it seems pretty simple to lift the cap on long term care. The people living in nursing homes are isolated, depressed, and become non-coherent. Where people living in their own homes can interact with the community, work in the community, and enjoy recreation.

So, in conclusion I hope you strongly consider lifting the cap on long term care so everyone in Wisconsin can have a better life.



## TESTAMONY

BEING ON A WAITING LIST FOR A SERVICE IS  
MUCH LIKE BEING ON HOLD WITH YOUR CABLE PROVIDER.  
WE HAVE LONG LISTS OF PEOPLE WHO ARE JUST  
HANGING ON TO THEIR PHONES FRUSTRATED IRRITATED WHO  
ARE JUST WAITING FOR THAT CABLE PROVIDER US TO  
PICK UP THE PHONE AND END THEIR TORMENTED  
SITUATION

HOW LONG MUCH LONGER ARE WE GOING TO MAKE THEM  
WAIT?

FAMILY CARE AND LONG TERM CARE ARE SERVICES  
THAT ARE NECESSARY SERVICES FOR COMMUNITIES OF  
PEOPLE WITH DISABILITIES THROUGHOUT THE STATE  
AND GET THEIR CAPPED AND <sup>WHERE</sup> ~~THESE~~ COMMUNITIES ARE PUT  
ON HOLD

I AM SICK OF AND TIRED OF HEARING THE PARTY LINE  
EXCUSE OF "WE'LL PUT YOU ON THE WAITING LIST"  
WE'RE PUTTING PEOPLE'S LIVES ON HOLD AND SIMPLY  
TELLING THEM TO WAIT FOR WHAT AND FOR HOW  
LONG ~~MONTHS~~ DAYS, MONTHS YEARS AND THEN CHANGING  
IN WAITING ON A SERVICE A LITTLE <sup>PAST</sup> TO LONG &  
RESOURCES THAT COULD EITHER BOTH ENRICH AND HELP THEIR  
LIVES TREMENDOUSLY FOR QUITE POSSIBLY YEARS UP TO  
FIVE TO SIX YEARS NOW

IT SICKENS ME DISTURBS ME AND TRULY ANNOYS ME  
THAT WE HAVE TURNED A ~~DETER~~ AND HAVE IGNORED



WHAT'S MOST IMPORTANT the people, themselves  
here tormented waiting for long term family  
care services  
the caps need to be lifted now so that we  
can end that tormented waiting take them off  
perpetual hold and give them the gift of long  
term family care services and focus on what's  
very important the ~~the~~ communitys of people with  
intellectual and developmental disabilities.





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February 9, 2012

To: Members, Senate Committee on Health

From: Ben Barrett, Chair  
Independent Living Council of Wisconsin

Re: SB 380 – Removing the Cap on Enrollment in Family Care, IRIS and Partnership and allowing for Program Equity Statewide

The Independent Living Council of Wisconsin submits testimony today regarding SB 380 – the bill that would remove the enrollment cap on Wisconsin's cost-effective, popular, and necessary community-based long-term care system and allow statewide growth so people will have equal access to programs that will allow them to receive the services they need in the community.

The primary purpose of the Independent Living Council is to plan for services throughout Wisconsin to support the independence of people with disabilities. As required by law, the majority of our council is people who live with a disability. Through an extensive and thorough public input process, the council ensures that our three-year State Plan for Independent Living responds to and addresses the needs of the 650,000 people with disabilities in Wisconsin. For more than a decade, Wisconsinites have stated their need for a comprehensive, community-based, long-term care system that is available in all 72 counties. No issue is more crucial to people's independence than having the right services and supports available in their communities.

Without these essential services people will have no choice but to put further strain on family members or move into more costly nursing homes. Neither choice is acceptable. You have heard testimony from many individuals who rely on these services daily in order to continue to be active and vibrant participants in their communities. You've also listened to stories from some of the more than 8,000 people who, because of the enrollment caps, sit on waiting lists, unable to receive the services they need.

Because community living is so crucial to the lives of people with disabilities the Americans with Disabilities Act provides that services for people with disabilities must be provided in the most integrated setting appropriate for the person. This rule was upheld by the Supreme Court in *Olmstead vs. LC* in 1999.

Most recently, this policy was reflected in a letter from the US Department of Health and Human Services. The department's regional administrator instructed the Wisconsin Department of Health Services to "immediately enroll" eligible people into the Family Care and Self-determination waivers. As demonstrated by the Department of Health Services and others today, this is not only the law but economical and good policy.

Eliminating the caps on enrollment will serve many Wisconsinites, but it's not enough. Without continuing our commitment for expansion statewide, people with disabilities in 15 counties in Wisconsin will wait indefinitely to receive the services for which they are entitled.

The overwhelming majority of people with disabilities who are eligible for Family Care and its related long-term care programs want to receive the supports they need and live in their own homes, which costs significantly less than providing services in institutional settings. Furthermore, according to data from the Department of Health Services, the average cost per member per month in Family Care or IRIS costs Wisconsin taxpayers less than providing services through the previous system of legacy waivers.

Keeping people in their homes in the community, where they want to live, with services and supports from Family Care, and its related programs, is a smart, cost-effective, long-term solution for all the people of Wisconsin.

The Independent Living Council of Wisconsin thanks both Senator Moulton and Senator Vukmir for their leadership on this important issue.

Thank you for your consideration of this testimony. If you have questions, please contact William Parke-Sutherland, Project Coordinator, at 608-256-9257 or [williamsps@ilcw.org](mailto:williamsps@ilcw.org).

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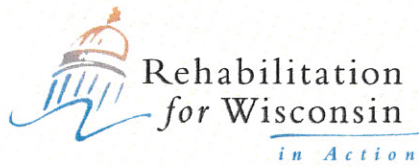
Please say no to the potential of losing our federal funding match for the Wisconsin family care program by lifting the caps that will limit its expansion. The state monies invested in the program would provide fiscally sound supports for people in need of critical care and/or help with activities of daily living in order to keep them within the community and out of costly institutions. When this happens, not only are financial savings realized, but the elderly and people with disabilities are ensured their right to be valued members of society. That in itself is priceless.

Working in partnership to maintain the viability of this program is essential. My son, Camden, will require transitional services and support when he crosses the bridge from the children's long term support system to the adult system in order for his care to continue without interruption. Caps on family care will mean waiting lists and waiting lists mean road blocks on that path of care continuity.

There are financial and functional screens in place to ensure that this funding is directed to the people for which the assistance was intended- those with substantial long term support needs. Family care should be looked at as an asset rather than a debt. The monies invested improve the quality of life for the people this program supports. *There are currently ~100 people on waiting lists in Washington*

Backing the history of proven success with the family support program by lifting the caps will confirm your dedication to the safety and wellbeing of our great state. I thank you for that. *County & 8,000 Statewide.*





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TO: Senator Vukmir, Chair and Senator Galloway, Vice-Chair, Senate Health Committee

CCs: Senator Moulton, Senator Erpenbach, and Senator Carpenter

FROM: C. Thomas Cook, Executive Director, *RFW in Action*

RE: February 9, 2012 Hearing on Family Care

DATE: February 9, 2012

Rehabilitation for Wisconsin in Action, Inc. (*RFW in Action*) is a statewide, nonprofit membership organization which supports and promotes the interests of community rehabilitation programs (CRPs) that enable people with disabilities and economic disadvantages to live and work in their local communities. *RFW in Action's* 60 member organizations provide services for more than 75,000 citizens with disabilities and economic disadvantages and employ more than 10,000 staff members throughout Wisconsin.

*RFW in Action* was an early supporter of requests that were made for an audit of the Family Care program. We were somewhat disappointed with the audit, itself, and understand that the Audit Bureau had difficulty in determining the answers to a number of questions. The ones that were of most interest to us were found in the section of the report on pages 67 – 70, which framed questions about the sustainability of the program; the sufficiency rates and their effect on the provider network; the strategic vision for the program, going forward; and the possibility of incorporating acute care along with long term care services into Family Care.

In response to the questions that were asked in a *Journal Sentinel* interview in June 2011, Governor Walker said he would be willing to lift the caps on enrollment that were included in the state budget that was passed, but wanted the issues identified in the Family Care audit to be addressed by the Department of Health Services (DHS) first. Governor Walker's announcement on December 28, 2011 to lift the enrollment caps and the publication by DHS of their draft plans for "2011 – 2013 Long Term Care Sustainability" has put the issues with Family Care back before the legislature. *RFW in Action* believes it is important to remove the enrollment caps in the Family Care counties as soon as possible accompanied by the allocation of adequate funding to meet the needs of people coming off the waiting lists. However, *RFW in Action* members who provide services in non-Family Care Counties are concerned about expanding the program before the issues that we identify below have been resolved.

*RFW in Action* continues to be concerned about whether Family Care is a sustainable program as it is currently structured.

- The Legislative Audit Bureau's report on Family Care could not verify the cost-effectiveness or sustainability of the program. It is too soon to tell whether the plans laid out by DHS will put the program on a sustainable path.
- The December 2010 APS Healthcare evaluation of Family Care found serious concerns with the financial viability of four managed care organizations (MCOs), if policies in place

at the time of the evaluation were to be continued. Aside from the enrollment caps, rate cuts to providers, and the sustainability plans that were put together in 2011, it does not appear that major policy changes have been implemented since then.

- Without a sufficient amount of working capital being held by an MCO when it begins operations, a substantial amount of funding is diverted from services into the creation of reserves required by the Office of the Commissioner of Insurance. The problem of diverting dollars away from direct services also exists for those MCOs that used their own capital to finance expansion needs, with the understanding that their reserves would be replenished by DHS. A plan to repay the MCOs for investing in the expansion was never put in place.
- DHS does not have a clear process for risk-sharing and establishing reinsurance thresholds, similar to those used in other states that have implemented managed long term care. If these kinds of policies are not put in place, financial issues experienced by MCOs may result in further provider attrition within the MCO's service network. A number of residential providers have already closed Adult Family Homes and Community Based Residential Facilities because of inadequate funding, leaving some areas of the state with few options for out-of-home care, which is most urgently needed when the parents of people with intellectual and developmental disabilities living at home become unable to continue caring for their family member because of illness or death. Some MCOs have suggested that the hundreds of relocations that took place over the last few years were a good thing for the individuals involved, but without active quality assurance efforts, the replacement services may end up threatening the health and safety of individuals.
- During the presentation on the enrollment caps on Family Care, which took place during the Senate Health Committee hearing held on October 5, 2011, DHS made reference to finding additional savings to offset the \$106 million in savings that were accomplished by the enrollment cap. While we question how this will be accomplished without compromising service quality, the bigger issue may be the number of people they estimated would be taken off the waiting list and those who still need to be converted to Family Care (16,000) from the "legacy" waivers, as outlined on Slide 8 of their presentation, once the caps are removed and expansion continues. DHS estimated this expansion would take the program spending from the \$1.5 billion a year that is spent, now, to \$2.1 billion. That would appear to be a \$600 million difference that is not budgeted for Family Care. While the replacement and reduction in the legacy waiver costs for the expansion counties would partially offset this increase, a reasonable question to ask DHS would be, "have you budgeted enough funding for the continued expansion of Family Care?" The last administration also budgeted savings from the conversions of legacy waiver enrollees to Family Care, which in the short run made the state's budget deficit larger because the expected savings were not achieved.
- The December 13, 2011 letter from the Centers for Medicare and Medicaid Services addressed issues with the state's need to get federal approval for the enrollment cap prior to implementing it in counties that would have reached entitlement status as of the date the cap was imposed. It was silent with respect to the expansion of the program. Given continuing questions about Family Care, *RFW in Action* believes it would be prudent to take a "go slow" approach to bringing in additional counties, until the effect of the DHS Sustainability Plans become more visible.

*RFW in Action* also has another major concern, which was cited as an issue by the Legislative Audit Bureau's report, as to whether rates paid to providers by MCOs are sufficient to maintain a viable long-term care service network, including the need to increase number of caregivers that

will be available to meet Wisconsin's long term care needs over the next decade, even with the expected advances in the use of technology to reduce the need for paid staff.

- The state's provider associations (including, but not limited to, *RFW in Action* and the Residential Services Association) continue to receive reports from their members that demonstrate that the MCOs most at risk of financial insolvency have made radical rate reductions to providers in the last two years and anticipate making additional cuts to providers in 2012. Last year this resulted in service disruptions to vulnerable adults with intellectual and developmental disabilities, including reduction in hours of service and numerous residential relocations.
  - For people with serious behavior issues, funding reductions created a "revolving door" of movement through residential programs, in which people were being moved from well-supported homes, to lower-cost providers where they failed and had to be placed in institutional programs, then were sent back to well-supported homes. We regard this as a form of systemic abuse of the individuals with intellectual and developmental disabilities (I/DD).
  - One Community Rehabilitation Program (CRP) contracts with an MCO that reported publicly that their capitation rates were decreased by 18% in 2012. That kind of cut in the funding to the MCOs does not comport with a promise to bring people off the waiting lists. This CRP expects additional rate cuts this year (last year their rates were cut from 25%-50% in their Supported Employment Program). Again, this will lead to further deterioration in program quality and attrition in available services. Quite simply, they can't afford to provide Supported Employment services to any additional members of this MCO.
  - Currently, residential providers (including small, owner-occupied Adult Family Homes serving people with I/DD) under contract with one MCO are reporting rate cuts of 40% are being made this year, which will likely put many of them out of business.
- Serious allegations that MCOs are engaging in practices that discriminate against people with intellectual and developmental disabilities in violation of federal law and relevant Supreme Court decisions, were made last year by Attorney Rock Pledl. He cited the targeting services to people with intellectual and developmental disabilities for disproportionate reductions in funding and the misuse of the Wisconsin Long Term Care Functional Screen as two prime examples.

Other states appear to have designed long-term managed care programs in a more effective manner, with adequate oversight of program quality. If Wisconsin wants to retain a managed care model, instead of converting it to a system of self-directed supports for people with intellectual and developmental disabilities (using IRIS and other Self-Directed Support models) that enables more funding to flow through for services, DHS should make additional efforts to revise a number of policies, after consultation with these other states. To their credit, DHS has developed some good ideas for doing this in its draft Sustainability Plans, such as their plans to examine and begin to restrain the MCOs' administrative and care management costs and to eliminate redundant services provided by the MCOs.

But there are some ideas that they included in the Sustainability Plans that we think are questionable. As a case in point, we believe keeping extended employment supports under DHS will not be as effective as the *RFW in Action* proposal to transition them to the Department of Workforce Development. Our association had little-to-no input in the development of the DHS plan to make employment sustainable, despite the fact that CRPs provide 65% of the supported employment funded by the Division of Vocational Rehabilitation, most of the

extended employment supports, and all of the center-based prevocational and day habilitation services.

We also question how realistic it will be for DHS to accomplish all of the plans they have outlined, because the scope of changes they propose making in some areas is very broad and some of the changes they have proposed may not have the kind of impact on long term care spending they expect, especially in the short term. For example, while DHS proposes placing greater reliance on families to keep individuals with intellectual and developmental disabilities in their homes as long as possible, as an alternative to the current utilization of residential services, there is not very much detail as to how this is going to be accomplished (i.e., whether supports offered to families will be sufficient to deal with medically- or behaviorally-challenged individuals, for example). Our greatest fear is that by attempting to make their Sustainability Plans budget neutral, the availability of services will be significantly diminished due to service network attrition, which would be another huge concern for the Centers for Medicare and Medicaid Services.

In addition to the concerns listed above, we recommend making the following changes to make Family Care more effective:

- Make both the Managed Care Organization (MCO) capitation and provider rate setting processes more transparent to avoid the “black box” phenomenon, in which hidden assumptions drive the distribution of funding.
- Set up systems for ongoing communication opportunities for all the stakeholders in the managed care system, including consumers and providers. For example, DHS could require all MCOs to establish consumer and provider advisory councils.
- Restore the status of providers as members of interdisciplinary (care management) teams for people with intellectual and developmental disabilities, as is done in every other state in the USA.
- Establish a process for ensuring full informed choice for services, especially for prevocational services, so that consumers are not required to choose integrated employment goals with which they disagree in order to receive pre-vocational services.
  - Discontinue the use of six-month prevocational services reports that are premised under the assumption that people with disabilities and their families / guardians have chosen the wrong service option.
- Involve the full care management team in person-centered planning, including the resource allocation decision-making process, to drive funding decisions in the future.
- Replace or supplement the Wisconsin Long Term Care Functional Screen with an assessment that has greater validity for people with intellectual disabilities, such as the Supports Intensity Scale, which is used by an increasing number of states to make resource allocation decisions. Require MCOs to set provider rates for services for people with intellectual and developmental disabilities based on consumer needs, as determined by a valid assessment for these individuals.
- Develop a core group of Specialists with hands-on experience in the provision of services to people with intellectual and developmental disabilities under the DHS Division of Long-Term Care, to provide needed state-level expertise, oversight, and guidance to the MCOs in services to this population.
- Use a single third-party administrator for claims adjudication and payments, to reduce the confusion over billing processes and to be more cost-effective (currently, most providers that deliver services in multiple counties must have dedicated billing specialists to navigate the confusing systems). Payment processes should be standardized throughout the State.

- Create regional organizations to supervise the independent consultants who coordinate services for people enrolled in the IRIS program, instead of having one statewide contract, allowing the current management company (TMG) to carve out some areas in the state in which they would continue to play this role.
- Collect consumer satisfaction data from a wider sample of people with intellectual and developmental disabilities and their family members or guardians on at least an annual basis, using an efficient process such as uSPEQ, a web-based survey developed by the Commission on Accreditation of Rehabilitation Facilities, instead of the cumbersome, time-consuming, and expensive PEONIES interview process.
- The Medicaid funding that is currently being spent on supported employment should be clearly identified and segregated into a dedicated funding stream, so we can set realistic financial goals for funding job development and other services to increase the number of people in supported employment. If this is not done, long term employment supports are not going to be a priority for the MCOs, given everything else they are expected to do with their Per Member Per Month capitated payments, as they attempt to meet the needs of the three target groups served by the MCOs.



February 9, 2012

Senator Leah Vukmir, Chair  
Senate Committee on Health  
Room 131 South, State Capitol  
P.O. Box 7882  
Madison, WI 53707

Senator Vukmir:

RE: **Senate Bill 380** to Remove the Enrollment Caps on Family Care and other Long Term Care Programs

The Northeast Wisconsin Family Care District supports the passage of Senate Bill 380 without any amendment.

The Northeast Wisconsin Family Care District (NEW FC) was established in October 2010 after over four years of planning in the region by the Counties of Brown, Door, Kewaunee, Marinette, Menominee, Oconto and Shawano. Each County Board passed a resolution to establish NEW FC. Our Board is currently comprised of one member appointed by each County and three consumer members for a total of ten members.

After the 2005 APS study of the five county Family Care pilots showed annual savings of over \$5,400 per participant, the Governor and Legislature decided to expand Family Care. In early 2006, the State announced its intention to expand Family Care to the entire state by the end of 2011.

The seven counties NEW FC serves received a State Planning Grant in July 2009, hired staff in early 2010 and planned for a March 1, 2012 start up of operations. However, in early 2011 the State put a cap on further enrollment as of July 1, 2011 and halted further expansion of Family Care unless the Secretary of Health Services determined that expansion would be more cost effective than current programs.

The Department of Health Services shared information at the November 1, 2011, meeting of the Wisconsin Long Term Care Council that Family Care was more cost effective than the county administered programs which are referred to as Legacy Waivers. The per member per month cost for Family Care was \$3,187.83 versus \$3,760.54 for Legacy Waiver Programs. It is important to note that Legacy Waiver costs do not include nursing home costs and Family Care does, which represents an additional \$233.34 per member per month in savings for Family Care. The result is a total savings of over \$800.00 per month with Family Care over Legacy Waivers.

This conclusion was consistent with the analysis that NEW FC had completed early in 2011. The Department had provided NEW FC with long term care cost, Medicaid cost and Long Term Care Functional Screen data for 2007-2009 for people receiving long term care services in our seven county region. We hired an actuarial firm to analyze the data and provide us with costs on a per member per month basis by county and by the three Family Care groups which are persons with developmental disabilities, persons with physical disabilities and elderly with chronic care conditions. We then compared our 2009 historic costs with the average costs of the Family Care Organizations (MCOs) as reported in the 2011 Legislative Audit Report on Family Care. Our costs for the county administered programs were higher than the average of Family Care Organizations. By moving to Family Care in our region and achieving the lower costs that the existing Family Care Organizations have been able to achieve, the State will achieve savings.

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*Northeast Wisconsin Family Care is a member driven organization passionate about delivering service options by supporting personal choices which promote the greatest opportunity for an independent quality of life, in a caring, respectful, and efficient manner.*



We recently completed an additional analysis to determine whether the savings that the District expects to achieve will be sufficient to absorb all the people on the current waiting lists and additional growth that may occur. The Legislative Fiscal Bureau has noted that in the early years of Family Care expansion, the State saves money. While the Legislative Fiscal Bureau looks at a three year time horizon, our analysis looked at five years. Our analysis indicates that over a five year period, there will be net savings to the State. This five year analysis demonstrates that Family Care is sustainable.

Our analysis included the following variables: County Contributions (reductions in State allocations to counties for their long term care programs), savings in Medicaid Card costs, efficiencies achieved based on the experience of existing Family Care Organizations, attrition of higher cost members who formerly received services in the county administered programs, and the cost of new members who had not been receiving long term care services. Existing Family Care Organizations (Managed Care Organizations) have observed that new members who had not been receiving long term care services are lower cost than members who had been receiving services in the county administered programs.

We have the benefit of not being the first organization to move into Family Care. We have visited current Managed Care Organizations and they have shared with us what they have learned. We have incorporated their advice as well as direction from the Department in our planning.

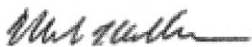
We look forward to being able to move ahead with Family Care in Northeast Wisconsin. Currently, there are about 2,500 citizens receiving long term care services and approximately 1,200 citizens on waiting lists. Counties within our district are anxious to finalize transition plans so the consumers that have been waiting, sometimes for years, for service are able to receive the support they deserve. For those that have concerns about expansion, the question they need to answer is: do they want to continue an old inefficient costly program that does not serve those that need services, or do they want a cost effective, managed care program that will serve all those in need while saving precious tax dollars?

We urge your approval of Senate Bill 380 without amendment. This will lift the caps on Family Care Enrollment. No legislation is required for expansion to those few remaining counties without Family Care or IRIS because safeguards are in place. County boards must adopt resolutions in support of moving forward, DHS must certify that expansion is cost effective, the legislative Fiscal Bureau will analyze this as final approval rests with the Joint Committee on Finance through the passive review process.

Thank you for your consideration.



Rolf K. Hanson, CEO



Mark Moeller, Board Chair





# *Milwaukee County*

Supervisor Marina Dimitrijevic, 4<sup>th</sup> District

Date: February 9, 2012  
To: Senate Committee on Health  
Senator Leah Vukmir, Chair  
From: Supervisor Marina Dimitrijevic, Milwaukee County Commission on Aging  
4<sup>th</sup> Supervisory District, Milwaukee County  
Re: Senate Bill 380, relating to removing the cap on enrollment of Family Care

Chairperson Vukmir, Committee members, thank you for allowing me to speak to you today. I am County Supervisor Marina Dimitrijevic. For the past eight years, I have served the residents of Bay View on the Milwaukee County Board. In that capacity, I represent about 52,000 City of Milwaukee residents. For comparison purposes, each Supervisor in Milwaukee County roughly represents about the same number of people as a State Representative in the Wisconsin Assembly.

The Chair is from Milwaukee County and is familiar with our programs. For those Committee members who represent other areas of Wisconsin, Milwaukee County administers a Family Care Managed Care Organization and separately contracts with the State to operate resource centers. Milwaukee County also is in negotiations to provide Family Care services in the counties of Kenosha and Racine.

As of November 2011, there were 37,560 total members served statewide in these long-term care programs (Family Care, Family Care Partnership, and the Program for All-inclusive Care for the Elderly). Of that statewide total, 27% of these residents live in Milwaukee County and 8,657 are enrolled in Family Care. The Milwaukee County Department of Family Care manages the care for 7,700 of those individuals. In its 2011 report, the non-partisan Legislative Audit Bureau found the Milwaukee County Department of Family Care to be fiscally sound. A short summary of their findings is attached to this written testimony.

Today, I urge the Legislature to comply immediately with last year's directive from the federal government to lift the enrollment cap on the Family Care program. Further legislative or administrative delay is unacceptable. The sluggish response to the Centers for Medicare and Medicaid Services potentially jeopardizes federal funding and is resulting in the wrongful, and possibly illegitimate, denial of benefits. Inaction harms both elderly residents and persons with disabilities.

With the implementation of the enrollment cap, the State has made Milwaukee County's most vulnerable citizens wait for long-term care services. As a member of the Commission on Aging, I can report that the Aging Resource Center of Milwaukee County has wait-listed more than 600

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people for long-term care services because of the enrollment cap. The growth of this waiting list reverses a decade long trend in Milwaukee County, where there has not been a waiting list for elderly residents since 2002. With the implementation of the enrollment cap, the waiting list for younger persons with disabilities is around 1,500. In Milwaukee County, many of these individuals have been waiting for years.

Today's action by the Senate Committee on Health is a step in the right direction. The Assembly Committee on Aging and Long-Term Care should follow suit and hear Assembly Bill 477, the companion legislation to Senate Bill 380.

The Department of Health Services promises to implement reforms to the Family Care program that will achieve sufficient efficiencies to internally fund the costs associated with lifting the cap. The Department should not be allowed to act unilaterally to implement these reforms without public or legislative oversight.

The appropriate standing committees of both the Senate and the Assembly should exercise their oversight responsibilities to ensure the Family Care benefit is not diminished as a result of the proposed modifications. With the implementation of the reforms, the Department must demonstrate that the safety, health and welfare of our residents will be maintained.

At a minimum, it is critical that the Department hold public hearings in Milwaukee County to solicit feedback on the proposed reforms. The Committee's support of this request for a public hearing in Milwaukee County would be appreciated. For the Committee's review, the initial response from the Milwaukee County Department of Family Care and resources centers to the proposed reforms is attached. The Chairman of the Milwaukee County Board has shared these reports with the Governor and the Secretary as well.

For example, the Department should carefully consider community need as it proposes to increasingly rely on natural supports as a mechanism to achieve cost-savings. About one-third of Milwaukee's population lives in poverty, and these residents may lack a support system that can financially sustain additional responsibilities. Assuming the care of a frail elder or a younger person with disabilities may be more they can handle financially.

In his State of the State address, the Governor touted that the provision of additional funding for Medicaid allowed for the expansion of Family Care...*"all across the State."* Yet, the wait list for long-term care services persists today.

The enrollment cap never should have been instituted in the first place. Individuals on a waiting list for Family Care services deserve immediate placement and their families deserve a fair and consistent outcome. Every day that the State fails to change its course is a day too many.

Our residents remain in need and demand immediate corrective action from you. Therefore, I urge you to lift the enrollment cap on Family Care today.



1. Per the LAB Family Care audit, the Milwaukee County Department of Family Care (MCDFC) has the largest restricted reserve fund to protect against insolvency. Sizes ranges from \$1.4 million for Community Health Partnership to \$3.4 million for the Milwaukee County Department of Family Care.

2. Results of our Member Satisfaction Survey:

**89.8%** of Members report they are satisfied with the work their social worker and nurse does for them “Always” or “Most of the time” (68% & 21.8%)

**89.8%** of Members report they are satisfied with the work their social worker and nurse does for them “Always” or “Most of the time” (68% & 21.8%)

**93.8% & 93.3%** of Members report they get help from their CM and RN when they need it “Always” or “Most of the time” (81.3% & 12.5%) and (76.3 & 17%)

**92.8%** of Members report they would recommend our program to a friend, “Always” or “Most of the time” (77.1% and 15.7%)

**94.3%** of Members report they are comfortable w/ the people who help them w/ their personal care, “Always” or “Most of the time” (76.6% & 17.7%,)

**92.9%** of Members report they are happy with the quality of the services provided, “Always” or “Most of the time” (66.4% & 24.2%)

**90.80%** of Members report they are happy with the timeliness of the services provided “Always” or “Most of the time” (65.6% & 25.2%)

**87%** of Members report they Participate in Decisions about the Services they Receive “Always” or “Most of the time” (61% & 26%)

3. Excerpts from our most recent audit by Metastar, the state's External Quality Review Organization:

"MCDFC exhibited the following strengths. . .:

- The quality program is active within the MCO with numerous initiatives and regular reporting.
- The quality work plan is organized effectively with multiple objectives and measurable indicators.
- The MCO has detailed data available based on customization of its information technology systems.
- MCDFC completed a key quality initiative:
  - a) The MCO developed a care management core competency test instrument and completed testing.
  - b) The internal file review process was fully implemented."





DEPARTMENT OF HEALTH & HUMAN SERVICES  
DISABILITIES SERVICES DIVISION

*Milwaukee County*

Héctor Colón • DHHS Director  
Geri L. Lyday • DSD Administrator

Combined Community Services Board

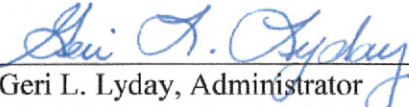
John Doherty, Vice Chair


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Ericka Rush  
Rev. Louis Sibley  
Cathy Simpson

To: County Board Chairman Lee Holloway  
From: Geri L Lyday, Administrator, Disabilities Services Division  
Stephanie Sue Stein, Director, Department on Aging  
Date: January 24, 2012  
Subject: Review of DHS "Long Term Care Sustainability" proposed modifications to Family Care program

The Disabilities Services Division and the Department on Aging have reviewed the draft Long Term Care Sustainability proposals from the Wisconsin Department of Health Services (DHS). Our feedback comes from the perspective of our dual roles as operators of the Aging and the Disability Resource Centers and as advocates for people who comprise our target populations, a role required in our Wisconsin Aging and Disability Resource Center (ADRC) contracts.

Our responses are attached and include Attachment 1 from the Disabilities Services Division Disability Resource Center and Attachment 2 from the Department on Aging, Aging Resource Center.

  
Geri L. Lyday, Administrator  
Disabilities Services Division

  
Stephanie Sue Stein  
Director, Department on Aging

Cc Chris Abele, County Executive  
Supervisor James "Luigi" Schmitt, Chairman Intergovernmental Relations Committee  
Supervisor Peggy Romo West, Chairperson Health and Human Needs Committee  
Amber Moreen, Chief of Staff, County Executive  
Terrence Cooley, Chief of Staff, County Board  
Hector Colon, Director, Department of Health and Human Services  
Roy de la Rosa, Director, Intergovernmental Relations  
Kelly Bablitch, Assistant Director, Intergovernmental Relations  
Carol Mueller, Committee Clerk, Intergovernmental Relations Committee



## **Milwaukee County Disabilities Services Division comments regarding DHS “Long Term Care Sustainability” proposed modifications to Family Care program**

The Disabilities Services Division reviewed DHS’s draft Long Term Care Sustainability proposals. Our feedback comes from two perspectives. We considered the proposed modifications that directly relate to the role and responsibilities of resource centers. As part of our ADRC State contract-required role to provide advocacy on behalf of people with disabilities and systems advocacy “related to the long term care delivery system,” we also offer feedback from that perspective.

### **Living Well at Home and in the Community**

- The DRC does not receive sufficient funds in its State contract to hire the staff necessary to carry out the proposed additional responsibilities such as medication compliance, nursing home diversion (responding within 7 days of admission), falls prevention, chronic disease self-management, short-term community intervention and care transitions. Current staff would be unable to take on these additional responsibilities.
- The lack of safe, accessible and affordable housing is a huge problem in Milwaukee County. It is unrealistic to expect the DRC to “secure affordable housing” for individuals with disabilities who don’t need residential care but are struggling to remain at home.
- We question whether automated in-home medication dispensing systems would work for individuals with cognitive disabilities without proper monitoring and assistance with preparation.

### **Youth in Transition**

- DHS references the experience of Dane County in developing community employment opportunities for youth with disabilities after graduation from high school. Milwaukee County’s employment environment is significantly different from Dane County’s and this would need to be recognized through additional resources to address Milwaukee’s challenges.
- The proposed modifications assume a lot about the support network of families if it is preferred that a youth remain with parents or family until he or she has community employment. Such family supports are not always the case in Milwaukee.
- The specific roles of the resource centers and the managed care organizations need to be clearly identified.
- The DRC would need additional resources, like the MIG Grant “Transitioning Services for Youth in the Disability Resource Center of Milwaukee Project” grant which is no-longer available but had provided critical resources for Youth in Transition programming, to have staff to serve as a “transition team” working with DVR, UWM, school districts, employment service agencies, parents and employers.
- MPS is a significant partner in Youth in Transition programming and they are clearly stretched to the limit fiscally. They have already cut collaborative programs such as the special Mobile Urgent Treatment Team (MUTT) for the Wraparound Milwaukee program for children with mental health needs.
- Working with the Children’s Long-Term Care system to begin transitional planning and discussion of community employment is a good idea and the DRC has done this in select situations but would require additional staff to accomplish this more completely.

**Employment Supports**

- The DRC supports the proposed modifications regarding assuring a continuum of employment supports in all Family Care programs.
- It is unclear who would complete the proposed Infrastructure Grant Funding activities. If these additional responsibilities were to be provided by resource centers then more funds would be needed.
- We support the funding of Work Incentive Specialists and hope that Milwaukee County is considered one of the 10 Family Care districts to be served by the Specialists. We question if 10 will be sufficient for the entire state.

**Family Care Benefits**

- Shifting from public supports to “natural supports” or families makes a huge assumption that an individual with disabilities has a family able and willing to provide supports, with resources, and not already burned-out from years of care.
- Using “natural supports” may be easier once a resource center is at entitlement and no longer has a wait list and can work with an individual and/or family sooner before families are desperate for service.
- The DRC is concerned about how the MCOs will implement the focus on natural supports. What will be in place to assure that individuals with disabilities and their families are not taken advantage of? Families should not be leveraged or feel “threatened” to provide support beyond their means. A family member should not have to unwillingly quit a job to provide care.
- The DRC is concerned about how these proposed modifications will be implemented and the timeline.
- The DRC strongly supports the proposed crisis intervention and stabilization modifications but notes that law enforcement should be included in the collaborations.

**Family Care Administrative and Program Efficiencies**

- Case management should be tailored to the needs of the individual who should have role in determining how much case management support he or she would need.
- The DRC agrees having more flexibility in using nurses to focus on those with more medical needs. We do not support not assigning and not evaluating a member’s medical needs but support relaxing the inflexible requirement regarding the number of nurse visits.
- The frequency of oversight in facilities that consistently meet licensure standards should not be reduced. Licensure focuses on compliance with facility standards while the interdisciplinary team provides needed quality oversight as it relates to the individual.
- Increased competition by allowing additional MCOs increases the staff resources needed in resource centers because of increased enrollment and dis-enrollment counseling. The DRC knows this first-hand and has never received funding from DHS in recognition of the additional workload.
- The DRC is concerned that the proposed modifications significantly tip the balance in favor of a more cost-driven approach to delivery of services rather than need-driven.

**IRIS and Self-Directed Supports**

- The DRC supports the proposed modifications for IRIS for the most part.
- Promoting use of technology to “move away from 24/7 one-to-one staffing” is very concerning for what it is saying for people who really need 24/7 supports.
- We assume that reference to including “an active guardian” in determining the amount of support an individual needs to self-direct does not mean that everyone has to have an appointed guardian.
- A tool to help assess if an individual can self-direct and what they are able to self-direct would be helpful.
- The DRC supports developing a “robust support broker system” since our experience has been that IRIS program staff is not always knowledgeable about local supports and services.

**Residential Services**

- The DRC is very concerned about the proposed modification which would require that options counseling be provided “to transition IRIS participants from restrictive to integrated settings in the community within 12 months of this change.” The DRC would need additional resources to provide options counseling to these additional individuals.
- Acuity should not necessarily drive where an individual lives. Some individuals with significant disabilities can live in an apartment with appropriate supports. The residential setting should not be driven by an individual’s physical condition but by their needs and abilities.
- Developing a continuum of more affordable, integrated, accessible and safe housing options in Milwaukee County should be the first sequential step in the proposed modifications related to residential services. Many individuals in Milwaukee are currently living in marginal situations which are unsafe, not accessible, and crowded.
- Independence for young adults graduating from high school should be encouraged and they should not be forced to live with their parents because of cost.

**Milwaukee County Department on Aging comments regarding DHS "Long Term Care Sustainability" proposed modifications to Family Care program**

The following analysis is in response to the proposed efficiencies to Family Care concentrating on those that will especially affect Frail Elders.

They fall into three categories/papers:

**1. Residential Options:** There are lots of issues in this paper.

- The first is making a residential benefit open only to persons who meet some level of acuity.
- The level or meaning of acuity is not defined.
- Persons with Alzheimer's Disease or other dementias often do not have physical acuity. They are often in the most need of residential care.
- What happens to persons who have no family or natural support.
- What happens to persons living in abusive situations.
- The Department spent two years trying to get a uniform payment system for residential care and stopped due to the myriad of issues involved in such an undertaking.
- So who will set and how will they set an upper limit of payment.
- The scope of services will eliminate amenities- what does that mean?
- What happens when people chose to move to Assisted living and then use all of their money - will MCO's move them?
- Where - or will they be directed to move on their own?
- Health and Safety are the two reasons given for approving residential care - Those are very broad categories left to the vagaries of MCO's - why doesn't the screen decide that?
- Who is going to re educate the entire residential care industry and consumers?

**2. Benefits**

- Who is going to compile and keep up with the cost of all benefits available in service areas.
- Why should cost be discussed with consumers who really have clear need of care - is the onus of cost containment being shifted to the guilt of persons who need long term care services and are poor?
- Persons are to be counseled to use their own resources - What Resources? I don't know any Medicaid beneficiaries with resources.
- Families are not asked to supplement any other Medicaid services - including Nursing Home Care- why only Family care?

## **MEMORANDUM**

**Date:** January 25, 2012  
**To:** Chairman Lee Holloway, Milwaukee County Board of Supervisors  
**From:** Maria Ledger, Director, Department Of Family Care  
**Subject:** Informational report on the 2011-2013 Long Term Care Sustainability Plan

Per your request, this report provides a brief analysis on the 2011-2013 Long Term Care Sustainability Plan prepared by the State Department of Health Services (DHS).

DHS states this plan is “ . . . a package of reforms and savings measures that will help make the program sustainable on an ongoing basis in the future while keeping consistent with the interests of current and future program participants.”

The Reforms by Focus Area are as follows:

- Employment Supports
- Family Care Administrative and Program Efficiencies
- Family Care Benefits
- IRIS and Self-Directed Supports
- Living Well at Home and in the Community
- Residential Services
- Youth in Transition

### **Employment Supports**

The proposed modifications in the area of employment would benefit both the MCO and members in the following ways:

- Improve Family Care members’ access to DVR services and funding through a statewide pilot that will leverage 80% federal matching funds, to facilitate prioritization of Family Care members to receive services to support community employment.
- Medicaid Infrastructure Grant (MIG) funding (\$1.6 million carryover) will allow for continued technical assistance and support from the Pathways office in the areas of youth in transition, Vocational Futures Planning model, supported employment network development and improved employment data collection:

- Work Incentive Benefits Counseling, currently very scarce in Milwaukee County, will help MCO participants decrease barriers to community employment by addressing the impact of earning money on their eligibility for needed benefits.
- There are proposed changes to the Medical Assistance Purchase Plan (MAPP) which allows working individuals to purchase Medicaid. These changes will allow MCO members with higher earnings to remain enrolled in Medicaid. These proposed changes will increase the State Income Maintenance workers tracking responsibilities of cost share.
- This proposal would support and encourage the MCO to register as an Employment Network in order to collect federal reimbursements under the Ticket to Work Act. This proposal will require a labor-intensive tracking process to capture payments. The MCO has explored this option through our Integrated Employment workgroup and has not found the efforts to be worth the funding that would result, given the current enrolled member population. Ticket to work is usually most successful with individuals who would not necessarily have met the functional eligibility for Family Care.

#### **Family Care Administrative and Program Efficiencies:**

The proposed modifications in the areas of Family Care Administrative and Program Efficiencies would impact members in the following ways:

- Under the heading of “**Streamline and Improve Care Management**” DHS states that their goal is to assure that care management is tailored to the needs of each individual, using a strength-based assessment process that identifies and utilizes natural supports when addressing member outcomes when planning for services and supports.
- It is important to note care management is already person-centered and should only be provided to the extent needed to meet member outcomes. The Milwaukee County MCO does regular chart audits to insure that all documented care management is appropriate.
- Another proposed reduction of care management is for members in facilities that have consistently met licensure standards and quality review as assessed by the State Division of Quality Assurance. Our concern is the number of community relocations will be drastically reduced. In CY 2011, the Milwaukee MCO relocated 552 individuals from Nursing Homes. 268 of these individuals went to community residential placements (AFH, CBRE, RCAC, SIL) and 284 returned to their homes. These moves to more independent setting required the care and coordination of care managers and nurses of the Interdisciplinary teams (IDTs).

The proposed modifications in the areas of Family Care Administrative and Program Efficiencies would impact the MCO in the following ways:

- If MCO authority to institute “checks and balances” to ensure that care plans reflect cost-effective choices is strengthened and MCOs implement a secondary review for high-cost products and services, it would be beneficial to have a DHS representative not only provide education to Administrative Law Judges but also attend Fair Hearings to co-represent the MCO. This would be markedly different than having the State’s External Quality Review Organization (EQRO) present at hearings representing members.
- The Milwaukee MCO has asked for years that the State work with persons in legacy waiver programs in advance of the transition to managed LTC programs to identify more integrated and cost-effective options in their home and community prior to enrolling in Family Care, IRIS, PACE or Partnership.

### **Family Care Benefits:**

The proposed modifications in the Family Care Benefits would impact members in the following ways:

- Currently, Family Care members can only be referred for disenrollment if they do not pay their cost share (All cost shares are calculated by State Income Maintenance Staff. Payment of cost shares by Family Care members is a condition of Family Care eligibility). If Family Care members live in an assisted living facility, they must pay the cost of Room and Board in that facility. Room and Board is not a covered benefit under Family Care. There is currently no way for MCOs to refer members for disenrollment if they do not pay their room and board. Some members will be much more diligent in paying their room and board if there is a consequence to their failure to pay.

The proposed modifications in the Family Care benefits would impact the MCO in the following ways:

- If DHS clarifies that program payments for social activities are limited to activities directly related to the long term care needs of the eligible person, it would be beneficial if this were communicated to stakeholders, advocates and Administrative Law Judges.
- As an MCO we have requested re-consideration of Over the Counter medications and supplies (OTCs) as a benefit in Family Care. DHS has considered this opinion but due to legislative language they are unable to remove this benefit without having cost consequences with medication remedials. We maintain that the costs that occur due to the burden of provision of this service outweigh these costs and would continue to advocate this be left out of the FC benefit package.

- Individuals who reside in group homes, nursing homes, adult family homes, etc. who do not pay their room and board impose a financial burden on the MCO. Further, their refusal to pay their room and board is unfair to the many members who do pay their bills timely. The Milwaukee MCO welcomes any mechanism that can be put in place to assist us in addressing this issue.

### **IRIS and Self-Directed Supports**

Although the description of this focus area is to strengthen program integrity and accountability of the IRIS program and ensure that self-direction in *IRIS and Family Care* (italics added for emphasis) maximize natural supports and the ability of consumers to choose the most integrated, community-based and cost-effective services, there is no mention in this section of the opportunity for members to self-direct all or some of their services within Family Care.

Over 40% of the Milwaukee County MCO members self direct their services.

There is no discussion in this focus area of the proposed requirement to limit the use of more restrictive residential settings in IRIS (including 8-bed CBRFs, 3-4 bed AFHs, RCACs, and assisted living facilities) to no more than needed to address participant health or safety needs *on a short-term basis*. This initiative seems to discriminate against persons with higher levels of care by prohibiting them from self-directing these services that meet their needs.

Per member per month (PMPM) costs of current IRIS participants (\$4159.30 PMPM) are already significantly higher than those of Family Care participants (\$3187.82 PMPM). The MCOs must be allowed to serve individuals with a wide range of needs. This is how every other insurance model works and to do so differently in this case will negatively impact Family Care to failure by requiring it to serve only the neediest individuals out of a pool of people who are already disabled, frail elderly or both.

### **Residential Services**

The proposed modifications in the areas of residential services would impact members in the following ways:

- Specifying acuity-based guidelines for utilization of more restrictive residential settings must take into account the level of natural supports available to the member. Families do not have a legal obligation to care for either their adult children or elderly family members. Furthermore, not every family is capable of caring for someone. If a member is not fortunate enough to have an intact and supportive family system, they should not be penalized by being “locked out” of certain levels of services, as long as those services are the right fit to meet their needs.

- The Milwaukee County MCO has already developed an innovative program to support More Integrated, Cost-Effective Options in Place of 24/7 Staffing. By implementing this model, which we refer to Supportive Independent Living (SILs) we have been able to successfully maintain 327 members in their own homes and apartments in partnership with agencies that arrange and support a range of services that support person-centered outcomes and self-directed care. 39 of these individuals moved from more restrictive settings to SILs.

The proposed modifications in the areas of residential services would impact the MCO in the following ways:

- Providing options counseling to transition IRIS participants from restrictive to integrated settings in the community and allowing members who do not wish to move to transition to a program that permits more restrictive residential settings (i.e. Family Care) results in adverse selection for the managed care programs. Why must MCOs be solely responsible for individuals with high care needs who may not have sufficient natural supports to enable them to live more independently in the community? In addition, IRIS should have the same responsibility as MCOs to work with newly enrolled members to “right size” services.

### **Living Well at Home and in the Community**

MCOs currently fulfill many of the following responsibilities for their members and will continue to:

- Improve Medication Compliance,
- Counsel new residents and their families in nursing home and assisted living about services in the community, arrange those services and help existing institutionalized Medicaid residents leave a facility for services at home,
- Expand the number of high-risk persons participating in evidence-based prevention programs to reduce hospitalization and/or need for long-term care,
- Expand the number of high-risk persons with multiple chronic diseases that participate in peer-led chronic disease self-management,
- Arrange for short-term practical community interventions to support people with modest means to remain at home,
- Screen vulnerable individuals to identify those diagnosed with Alzheimer’s disease or other dementia, to delay institutional placement by an average of 18 months and,
- Assist seniors and persons with disabilities leaving hospitals and making a transition to home

### **Youth in Transition**

The proposed modifications in the area of Youth in Transition would impact members in the following ways:

- Improving our members' access to DVR services and funding through a State-wide pilot which will leverage 80% federal matching funds, to facilitate prioritization of Family Care members to receive services to support community employment.

The proposed modifications in the area of Youth in Transition would impact the MCO in the following ways:

- The MCO has created a specialized training for IDTs along with tools and resources they may need. Our Integrated Employment workgroup and Best Practice Team mentoring in this area are available to all of our IDTs for ongoing support and assistance. Our provider network includes agencies that offer supported employment and Independent Living Services for members to maximize their self-determination and independence.
- The MCO currently has Policies and Guidelines to focus on Integrated Community Employment during the care planning process to facilitate a smooth school to work transition.
- The MCO welcomes the opportunity to participate in statewide school pilots designed to identify best/promising practices designed to expand community employment for youth in transition (note: youth between the age of 18 and 21 may still be attending High School while enrolled in Family Care)